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The Practice and Ethics of Sexual Orientation Conversion Therapy

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Sexual orientation conversion therapy was the treatment of choice when homosexuality was thought to be an illness. Despite the declassification of homosexuality as a mental illness, efforts to sexually reorient lesbians and gay men continue. The construct of sexual orientation is examined, as well as what constitutes its change. The literature in psychotherapeutic and religious conversion therapies is reviewed, showing no evidence indicating that such treatments are effective in their intended purpose. A need for empirical data on the potentially harmful effects of such treatments is established. Ethical considerations relative to the ongoing stigmatizing effects of conversion therapies are presented. The need to develop more complex models for conceptualizing sexual orientation is discussed, as well as the need to provide treatments to gay men and lesbians that are consonant with psychology's stance on homosexuality.

The question of how to change sexual orientation has been discussed as long as homoeroticism itself has been described in the literature. For over a century, medical, psychotherapeutic, and religious practitioners have sought to reverse unwanted homosexual orientation through various methods: These include psychoanalytic therapy, prayer and spiritual interventions, electric shock, nausea-inducing drugs, hormone therapy, surgery, and various adjunctive behavioral treatments, including masturbatory reconditioning, rest, visits to prostitutes, and excessive bicycle riding (Murphy, 1992). Early attempts to reverse sexual orientation were founded on the unquestioned assumption that homosexuality is an unwanted, unhealthy condition. Although homosexuality has long been absent from the taxonomy of mental disorders, efforts to reorient gay men and lesbians persist. Recently, for example, a coalition of mental health practitioners formed an organization dedicated to the "rehabilitation" of gay men and lesbians. Many practitioners still adhere to the officially debunked "illness" model of homosexuality, and many base their treatments on religious proscriptions against homosexual behavior. Still others defend sexual reorientation therapy as a matter of free choice for the unhappy client, claiming that their treatments do not imply a negative judgment on homosexuality per se. They seek to provide what they describe as a treatment alternative for men and women whose homosexuality is somehow incongruent with their values, life goals, or psychological structures.

Of the articles to be examined in this review, few have addressed the question of how sexual orientation is defined. Such a definition seems necessary before one can describe how sexual orientation is changed. However, most research in this area offers a dichotomous view of human sexuality in which undesired homoerotic impulses can be eradicated through a program that replaces them with heterosexual competence. Few studies even rely on the relatively simplistic Kinsey scale (Kinsey, Pomeroy, & Martin, 1948) to make an attempt at assessing a subject's sexual orientation. Although a comprehensive discussion is well beyond the scope of this article, I begin with a passing reference to what is meant by the terms *homosexuality* and *heterosexuality*.

The data of Kinsey et al. (1948) suggested that as many as 10% of American men considered themselves to be primarily or exclusively homosexual for at least 3 years of their adult lives. His assessment was based on the subject's actual behavior as well as the content of the subject's fantasy life. Subsequent efforts to quantify sexual orientation have incorporated gender-based, social, and affectional variables (Coleman, 1987). Several complex questions involved in the defining of sexual orientation have been either reduced or overlooked in the literature on conversion therapy. For instance, those conversion therapy programs that claim the greatest success included more subjects whose behavioral histories and fantasy lives appeared to have significant heteroerotic components (Haldeman, 1991). Instructing a "homosexual" subject with a priori heteroerotic responsiveness in heterosexual behavior appears to be easier than replacing the cognitive sociosexual schema and redirecting the behavior of the "homosexual" subject with no reported heteroerotic inclinations. Nevertheless, both types of "homosexual" subjects are often included in the same treatment group.

Any definition of sexuality based solely on behavior is bound to be deficient and misleading. Sense of identity, internalized sociocultural expectations, and importance of social and political affiliations all help define an individual's sexual orientation, and these variables may change over time. The content of an individual's fantasy life may provide information that is not influenced by the individual's need for social acceptance, but even these are subject, in some women and men, to variations in gender of object choice, based on environmental or political factors. Social demand variables also figure in describing sexual orientation, given the frequency with which gay men and lesbians marry (Bell & Weinberg, 1978). Writer Darrell Yates Rist examined the lives of gay men in rural America with respect to how sexual orientation is constructed (1992). He described "Sven," a heterosexually married father of two:

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> It occurred to me that there were men—perhaps most men—whom sexual labels failed. Rudy seemed to think of Sven as a gay man stuck with a wife. Others might describe him as "bisexual," yet a third sexual breed. But those terms, like "straight," signify a way of life in which sex is deemed the core of identity, the single Freudian need or act that controls the psyche and determines the scope of a human being . . . such a way of looking at sex was beginning to seem exotic to me, a precious myth. One might as sensibly concoct natural categories out of the sports men choose to play or the foods they eat, religious dogmas or politics—any multitude of the changeable preferences to which men and women devote themselves. (1992, p. 141)

The categories homosexual, heterosexual, and bisexual, conceived by many researchers as fixed and dichotomous, are in reality very fluid for many. Therefore, in addition to how sexual orientation is defined, one must also consider how it is experienced by the individual. For many gay men, the process of "coming out" may be likened to an internal evolution of sorts, a conscious recognition of what has always been. On the other hand, many lesbians describe "coming out" as a process tied to choices or social and political constructions. In this regard, many lesbians may have more in common with heterosexual women than with gay men, suggesting a gender-based distinction relative to the development of homosexual identity.

Questions about the complex nature of sexual orientation and its development in the individual must be addressed before change in sexual orientation is assessed. Many previously heterosexually identified individuals "come out" as lesbian or gay later in life, and some people who identify themselves as gay or lesbian engage in heterosexual behavior and relationships for a variety of personal and social reasons. How, then, are spontaneously occurring shifts in sexual orientation over the life span to be differentiated from behavior resulting from the interventions of a conversion therapist? Essentially, the fixed, behavior-based model of sexual orientation assumed by almost all conversion therapists may be invalid. For many individuals, sexual orientation is a variable construct subject to changes in erotic and affectional preference, as well as changes in social values and political philosophy that may ebb and flow throughout life. For some, "coming out" may be a process with no true endpoint. Practitioners assessing change in sexual orientation have ignored the complex variations in an individual's erotic responses and shifts in the sociocultural landscape.

Psychological Conversion Programs

The case for conversion therapy rests on its ability to understand who is being converted and its ability to describe the nature of the conversion taking place. Acknowledging the theoretical complexities and ambiguities left unaddressed by most conversion therapists, the first question is "Are these treatments effective?" In assessing the efficacy of conversion therapy, psychotherapeutic and religious programs will be reviewed. Those interested in reviews of medical therapies (drug or hormonal and surgical interventions) are referred to Silverstein (1991) and Murphy (1992).

Psychotherapeutic approaches to sexual reorientation have been based on the a priori assumption that homoeroticism is an undesirable condition. Two basic hypotheses serve as the foundation for most therapies designed to reverse sexual orientation. The first is that homosexuality results from an arrest in normal development or from pathological attachment patterns in early life. The second is that homosexuality stems from faulty learning. Therapies most closely associated with the first perspective are of the psychoanalytic and neo-analytic orientations.

Psychoanalytic tradition posited that homosexual orientation represented an arrest in normal psychosexual development, most often in the context of a particular dysfunctional family constellation. Such a family typically featured a close-binding mother and an absent or distant father. Despite the relative renown of this theory, it is based solely on clinical speculation and has never been empirically validated. Subsequent studies have indicated that etiologic factors in the development of sexual orientation are unclear but that the traditional psychoanalytic formulations concerning family dynamics are not viable (Bell, Weinberg, & Hammersmith, 1981).

Psychoanalytic treatment of homosexuality is exemplified by the work of Bieber et al. (1962), who advocate intensive, long-term therapy aimed at resolving the unconscious anxiety stemming from childhood conflicts that supposedly cause homosexuality. Bieber et al. saw homosexuality as always pathological and incompatible with a happy life. Their methodology has been criticized for use of an entirely clinical sample and for basing outcomes on subjective therapist impression, not externally validated data or even self-report. Follow-up data have been poorly presented and not empirical in nature. Bieber et al. (1962) reported a 27% success rate in heterosexual shift after long-term therapy; of these, however, only 18% were exclusively homosexual in the first place. Fifty percent of the successfully treated subjects were more appropriately labeled bisexual. This blending of "apples and oranges" returns us to the original question: Who is being converted, and what is the nature of the conversion?

Another analytically based study reported virtually no increase in heterosexual behavior in a group of homosexual men (Curran & Parr, 1957). Other studies report greater success rates: For instance, Mayerson and Lief (1965) indicate that, of 19 subjects, half reported engaging in exclusive heterosexual behavior 4.5 years posttreatment. However, as in Bieber et al.'s study, those subjects had heteroerotic traits to begin with; exclusively homosexual subjects reported little change, and outcomes were based on patient self-report. As in other studies, an expansion of the sexual repertoire toward heterosexual behavior is viewed as equivalent to a shift of sexual orientation.

California psychologist Joseph Nicolosi has developed a program of reparative therapy for "non-gay" homosexuals, individuals who reported being uncomfortable with their same-sex orientation. Nicolosi stated, "I do not believe that the gay life-style can ever be healthy, nor that the homosexual identity can ever be completely ego-syntonic" (1991, p. 13). This belief erroneously presupposes a unitary gay lifestyle, a concept more reductionist than that of sexual orientation. It also prejudicially and without empirical justification assumes that homosexually oriented people can never be normal or happy, a point refuted numerous times in the literature. Nonetheless, this statement is the foundation for his theoretical approach, which cites numerous studies that suggest that gay men have greater frequencies of disrupted bonds with their fathers, as well as a host of psychological concerns, such as assertion problems. These observations are

used to justify a pathological assessment of homosexuality. The error in such reasoning is that the conclusion has preceded the data. There may be cause to examine the potentially harmful impact of a detached father and his effect on the individual's self-concept or capacity for intimacy, but why should a detached father be selected as the key player in causing homosexuality, unless an a priori decision about the pathological nature of homosexuality has been made and unless he is being investigated as the cause? This perspective is not consistent with available data, nor does it explain the millions of heterosexual men who come from backgrounds similar to those of gay men, or for that matter, those gay men with strong father–son relationships. Nicolosi does not support his hypothesis or his treatment methods with any empirical data.

Group treatments have also been used in sexual reorientation. One study of 32 subjects reports a 37% shift to heterosexuality (Hadden, 1966), but the results must be viewed with some skepticism, because of the entirely self-report nature of the outcome measures. Individuals involved in such group treatments are especially susceptible to the influence of social demand in their own reporting of treatment success. Similarly, a study of 10 gay men resulted in the therapist's impressionistic claims that homosexual patients were able to "increase contact" with heterosexuals (Mintz, 1966). Birk (1980) described a combination insight-oriented–social-learning-group format for treating homosexuality. He claimed that overall, 38% of his patients achieved "solid heterosexual shifts." Nonetheless, he acknowledges that these shifts represent "an adaptation to life, not a metamorphosis," and that homosexual fantasies and activity are ongoing, even for the "happily married" individual (Birk, 1980, p. 387). If a solid heterosexual shift is defined as one in which a happily married person may engage in more than occasional homosexual encounters, perhaps this method is best described as a laboratory for heterosexual behavior, rather than a change of sexual orientation. A minority of subjects, likely with preexisting heteroerotic tendencies, may be taught proficiency in heterosexual activities. Eager to equate heterosexual competence with orientation change, these researchers have ignored the complex questions associated with the assessment of sexual orientation. Behavior alone is a misleading barometer of sexual orientation, which includes biological, gender-based, social, and affectional variables. No researchers who conducted conversion studies have displayed any such thoughtfulness in their assessment or categorization of subjects.

Behavioral programs designed to reverse homosexual orientation are based on the premise that homoerotic impulses arise from faulty learning. These studies seek to countercondition the "learned" homoerotic response with aversive stimuli, replacing it with the reinforced, desired heteroerotic response. The aversive stimulus, typically consisting of electric shock or convulsion- or nausea-inducing drugs, is administered during presentation of same-sex erotic visual material. The cessation of the aversive stimulus is accompanied by the presentation of heteroerotic visual material, supposedly to replace homoeroticism in the sexual response hierarchy. These methods have been reviewed by Sansweet (1975). Some programs attempted to augment aversive conditioning techniques with a social learning component (assertiveness training, how to ask women out on dates, etc.; Feldman & McCullogh, 1965). Later, the same investigators modified their approach, calling it "anticipatory avoidance conditioning," which enabled subjects to avoid electrical shock when viewing slides of same-sex nudes (Feldman, 1966). Such a stressful situation could likely inhibit feelings of sexual responsiveness in any direction; nevertheless, a 58% cure rate was claimed, with outcome criteria defined as the suppression of homoerotic response. Cautela (1967) reported on single subjects who were taught to imagine such aversive stimuli rather than undergo them directly. His later work focuses on structured aversive fantasy, in which subjects are asked to visualize repulsive homoerotic encounters in stressful circumstances (Cautela & Kearney, 1986). The investigators deny a homophobic bias to this therapeutic approach.

Other studies suggest that aversive interventions may extinguish homosexual responsiveness but do little to promote alternative orientation. One investigator suggests that the poor outcomes of conversion treatments are due to the fact that they "disregard the complex learned repertoire and topography of homosexual behavior" (Faustman, 1976). Other studies echo the finding that aversive therapies in homosexuality do not alter subjects' sexual orientation (McConaghy, 1981). Another study similarly suggests that behavioral conditioning decreases homosexual orientation but does not elevate heterosexual interest (Rangaswami, 1982). Methodologically, the near-exclusive use of self-report outcome measures is problematic, particularly in an area where social demand factors may strongly influence subjects' reports. The few studies that do attempt to externally validate sexual reorientation through behavioral measures show no change after treatment (Conrad & Wincze, 1976).

Masters and Johnson (1979) reported on the treatment of 54 "dissatisfied" homosexual men. This was unprecedented for the authors, as their previous works on heterosexual dysfunction did not include treatment for dissatisfied heterosexual people. The authors hypothesized homosexuality to be the result of failed or ridiculed attempts at heterosexuality, neglecting the obvious: that heterosexual "failures" among homosexual people are to be expected because the behavior in question is outside the individual's normal sexual response pattern. Despite their comments to the contrary, the study is founded on heterosexist bias. Gonsiorek (1981) raises a variety of concerns with the Masters and Johnson study. Of the numerous methodological problems with this study, perhaps most significant is the composition of the sample itself. Of 54 subjects, only 9 (17%) identified themselves as Kinsey 5 or 6 (exclusively homosexual). The other 45 subjects (83%) ranged from 2 to 4 on the Kinsey scale (predominantly heterosexual to bisexual). Furthermore, because 30% of the sample was lost to follow-up, it is conceivable that the outcome sample does not include any homosexual men. Perhaps this is why such a high success rate is reported after 2 weeks of treatment. It is likely that, rather than converting or reverting homosexual people to heterosexuality, this program enhances heterosexual responsiveness in people with already established heteroerotic sexual maps.

Evidence for the efficacy of sexual conversion programs is less than compelling. All research in this area has evolved from unproven hypothetical formulations about the pathological nature of homosexuality. The illness model has never been empirically validated; to the contrary, a broad literature validates the nonpathological view of homosexuality, leading to its declassi-

fication as a mental disorder (Gonsiorek, 1991). Thus, treatments in both analytic and behavioral modes are designed to cure something that has never been demonstrated to be an illness. From a methodological standpoint, the studies reviewed here reveal inadequacies in the selection criteria and the classification of subjects and poorly designed and administered outcome measures. In short, no consistency emerges from the extant database, which suggest that sexual orientation is amenable to redirection or significant influence from psychological intervention.

Religion-Based Conversion Programs

In a recent symposium on Christian approaches to the treatment of lesbians and gay men, one panelist said of his numerous unsuccessful attempts at sexual reorientation: "I felt it was what I had to do in order to gain a right to live on the planet." Such is the experience of many gay men and lesbians, who experience severe conflict between their homoerotic feelings and their need for acceptance by a homophobic religious community. This conflict causes such individuals to seek the guidance of pastoral care providers or Christian support groups whose aim is to reorient gay men and lesbians. Such programs seek to divest the individual of his or her "sinful" feelings or at least to make the pursuit of a heterosexual or celibate lifestyle possible. Their theoretical base is founded on interpretations of scripture that condemn homosexual behavior, their often unspecified treatment methods rely on prayer, and their outcomes are generally limited to testimonials. Nonetheless, these programs bear some passing examination because of the tremendous psychological impact they have on the many unhappy gay men and lesbians who seek their services and because of some psychologists' willingness to refer to them. Lastly, many such programs have been associated with significant ethical problems.

Gay men who are most likely to be inclined toward doctrinaire religious practice are also likely to have lower self-concepts, to see homosexuality as more sinful, feel a greater sense of apprehension about negative responses from others, and are more depressed in general (Weinberg & Williams, 1974). Such individuals make vulnerable targets for the "ex-gay" ministries, as they are known. Fundamentalist Christian groups, such as Homosexuals Anonymous, Metanoia Ministries, Love In Action, Exodus International, and EXIT of Melodyland are the most visible purveyors of conversion therapy. The workings of these groups are well documented by Blair (1982), who states that, although many of these practitioners publicly promise change, they privately acknowledge that celibacy is the realistic goal to which gay men and lesbians must aspire. He further characterizes many religious conversionists as individuals deeply troubled about their own sexual orientation, or whose own sexual conversion is incomplete. Blair reports a host of problems with such counselors, including the sexual abuse of clients.

The most notable of such ministers is Colin Cook. Cook's counseling program, Quest, led to the development of Homosexuals Anonymous, the largest antigay fundamentalist counseling organization in the world. The work of Cook, his ultimate demise, and the subsequent cover-up by the Seventh Day Adventist Church, are described by sociologist Ronald Lawson (1987). Over the course of 7 years, approximately 200 people received reorientation counseling from Cook, his wife, and an associate. From this ministry sprang Homosexuals Anonymous, a 14-step program modeled after Alcoholics Anonymous, which has become the largest fundamentalist organization in the world with a unitary antigay focus. Lawson, in attempting to research the efficacy of Cook's program, was denied access to counselees on the basis of confidentiality. Nonetheless, he managed to interview 14 clients, none of whom reported any change in sexual orientation. All but two reported that Cook had had sex with them during treatment. According to Blair, another homosexual pastor who used his ministry to gain sexual access to vulnerable gay people was Guy Charles, founder of Liberation in Jesus Christ. Charles was a homosexual man who had claimed a heterosexual conversion subsequent to his acceptance of Christ. Like Cook, Charles was ultimately disavowed by the Christian organization that sponsored him after charges of sexual misconduct were raised.

To date, the only spiritually based sexual orientation conversion program to appear in the literature has been a study by Pattison and Pattison (1980). These authors describe a supernatural healing approach in treating 30 individuals culled from a group of 300 who sought sexual reorientation counseling at EXIT of Melodyland, a charismatic ex-gay ministry affiliated with a Christian amusement park. The Pattisons do not explain their sampling criteria, nor do they explain why 19 of their 30 subjects refused follow-up interviews. Their data indicate that only 3 of the 11 (of 300) subjects report no current homosexual desires, fantasies, or impulses, and that 1 of the 3 subjects is listed as still being "incidentally homosexual." Of the other 8 subjects, several indicated ongoing neurotic conflict about their homosexual impulses. Although 6 of these men have married heterosexually, 2 admit to more than incidental homosexual ideation as an ongoing issue.

Recently, founders of another prominent ex-gay ministry, Exodus International, denounced their conversion therapy procedures as ineffective. Michael Busse and Gary Cooper, co-founders of Exodus and lovers for 13 years, were involved with the organization from 1976 to 1979. The program was described by these men as "ineffective . . . not one person was healed." They stated that the program often exacerbated already prominent feelings of guilt and personal failure among the counselees; many were driven to suicidal thoughts as a result of the failed reparative therapy ("*Newsbriefs*," 1990, p. 43).

The fundamentalist Christian conversion programs hold enormous symbolic power over many people. Possibly exacerbating the harm to naive, shame-ridden counselees, these programs operate under the formidable auspices of the Christian church, and outside the jurisdiction of any professional organizations that may impose ethical standards of practice and accountability on them. A closer look at such programs is warranted, given the frequency with which spiritual conversion programs seek to legitimize themselves with psychologists as affiliates.

An examination of psychotherapeutic and spiritual approaches to conversion therapy reveal a wide range of scientific concerns, from theoretical weaknesses to methodological problems and poor outcomes. This literature does not suggest a bright future in studying ways to reorient people sexually. Indi-

viduals undergoing conversion treatment are not likely to emerge as heterosexually inclined, but they often do become shamed, conflicted, and fearful about their homoerotic feelings. It is not uncommon for gay men and lesbians who have undergone aversion treatments to notice a temporary sharp decline in their sexual responsiveness, with some subjects reporting long-term sexual dysfunction. Similarly, subjects who have undergone failed attempts at conversion therapy often report increased guilt, anxiety, and low self-esteem. Some flee into heterosexual marriages that are doomed to problems inevitably involving spouses, and often children as well. Not one investigator has ever raised the possibility that conversion treatments may harm some participants, even in a field where a 30% success rate is seen as high. The research question, "What is being accomplished by conversion treatments?" may well be replaced by, "What harm has been done in the name of sexual reorientation?" At present, no data are extant.

Ethical Considerations

We have considered the question of whether sexual orientations are amenable to change or modification by means of therapeutic interventions. Of equal, if not greater, import is the question of whether psychology should provide or endorse such "cures." Ethicists object to conversion therapy on two grounds: first, that it constitutes a cure for a condition that has been judged not to be an illness, and second, that it reinforces a prejudicial and unjustified devaluation of homosexuality.

The American Psychiatric Association's 1973 decision to remove homosexuality from its *Diagnostic and Statistical Manual of Mental Disorders* marked the official passing of the illness model of homosexuality. The American Psychological Association (APA) followed suit with a resolution affirming this anti-illness perspective, stating, in part, ". . . the APA urges all mental health professionals to take the lead in removing the stigma of mental illness that has long been associated with homosexual orientations" (APA, 1975). Homosexuality was replaced with the confusing "ego-dystonic homosexuality" diagnosis, which was dropped altogether in 1987.

It is beyond the scope of this article to comprehensively review the literature on the depathologizing of homosexuality. Briefly, recent scholarship in the area suggests that human homosexuality, despite being nonreproductive in nature, is as biologically natural as heterosexuality.

> Biological arguments cannot be used to distinguish morally between homosexuality and heterosexuality. Like left- and right-handedness, the two are expressions of a single human nature that can be expressed differently in different individuals. If homosexuality is therefore part of a range of behavior that has molded *Homo sapiens,* then it is clear that homosexuality is not a disease, and certainly the general object should not be to 'cure' it. (Kirsch & Weinrich, 1991, p. 30)

Homosexual behavior and identity exist in many cultures, and its relative normalcy seems to be more a function of subjective social attribution than of intrinsic properties.

> Our society has taken a natural kind of sexuality and made it taboo, in a way that is completely unnecessary for its stability or its values. It is time for us to learn from other cultures that uniform sameness is not a desirable goal for society. (Weinrich & Williams, 1991, p. 59)

Proponents of conversion therapy continue to insist, in the absence of any evidence, that homosexuality is pathological. This model was rejected because of a lack of such evidence, and its demise has been described by Gonsiorek (1991). This review underscores the faulty logic inherent in classic psychoanalytic theories of family dysfunction as etiologic of homosexuality. Researcher bias, as well as methodological inadequacies, characterize studies supporting the illness model. Psychological test data, from Hooker's (1957) study to present-day studies, have been reviewed and show no substantive differences between homosexual and heterosexual subjects.

Were there properties intrinsic to homosexuality that make it a pathological condition, we would be able to observe and measure them directly. In reality, however, there exists a wide literature indicating just the opposite: that gay men and lesbians do not differ significantly from heterosexual men and women on measures of psychological stability, social or vocational adjustment, or capacity for decision making. In fact, psychological adjustment among gay men and lesbians seems to be directly correlated to the degree that they have accepted their sexual orientation (Weinberg & Williams, 1974). In light of such evidence, the number of studies examining the pathogenesis of homosexuality has diminished in recent years.

Davison (1976, 1978, 1991) has detailed many of the ethical objections to conversion therapies. A behavior therapist once well known for his program to change sexual orientation, Davison believes that a disservice is done to the gay or lesbian individual by offering sexual orientation change as a therapeutic option. In Davison's view, conversion therapy reinforces anti-gay prejudice. He asks, "how can therapists honestly speak of nonprejudice when they participate in therapy regimens that by their very existence—and regardless of their efficacy—would seem to condone the current societal prejudice and perhaps also impede social change?" (1991, p. 141).

In his paraphrase of Halleck (1971), Davison states that therapeutic neutrality is a myth and that therapists, by the nature of their role, cannot help but influence patients with respect to values. Davison suggests that the question of whether sexual orientation can be changed is secondary to the consideration that it should not be changed, because of the devaluation and pathologizing of homosexuality implicit in offering a "cure" for it. Because therapists operate from positions of power, to affirm the viability of homosexuality and then engage in therapeutic efforts to change it sends a mixed message: If a cure is offered, then there must be an illness. This point is echoed by Begelman, who stated that "(conversion therapies) by their very existence, constitute a significant causal element in reinforcing the social doctrine that homosexuality is bad; therapists . . . further strengthen the prejudice that homosexuality is a 'problem behavior', since treatment may be offered for it" (1975, p. 180). Charles Silverstein (1977), points to social factors (e.g., rejecting families, hostile peer interactions, and disapproving society) as being responsible for people seeking sexual orientation change. These authors indicate that what were historically viewed as "ego-dystonic" responses to homosexuality are really internalized reactions to a hostile society.

Proponents of conversion therapy often deny any coercive intent, claiming that theirs is a valuable service for distressed lesbians and gay men who freely seek their services. However, the concept that individuals seek sexual orientation change of their own free will may be fallacious. Martin (1984) stated that "a clinician's implicit acceptance of the homosexual orientation as the cause of ego-dystonic reactions, and the concomitant agreement to attempt sexual orientation change, exacerbates the ego-dystonic reactions and reinforces and confirms the internalized homophobia that lies at their root" (p. 46).

State psychological associations have started to address the issue of conversion therapy, to provide reasonable guidelines to consumer and practitioner. In 1991, the Washington State Psychological Association adopted an advisory policy on sexual orientation conversion therapy. Here, this policy is stated in part:

> Psychologists do not provide or sanction cures for that which has been judged not to be an illness. Individuals seeking to change their sexual orientation do so as the result of internalized stigma and homophobia, given the consistent scientific demonstration that there is nothing about homosexuality per se that undermines psychological adjustment. It is therefore our objective as psychologists to educate and change the intolerant social context, not the individual who is victimized by it. Conversion treatments, by their very existence, exacerbate the homophobia which psychology seeks to combat. (Washington State Psychological Association, 1991)

Discussion

Our understanding of human sexuality is entering a new era, one in which formerly sacrosanct assumptions and classifications are no longer applicable. A new generation of individuals, no longer self-identified as gay or lesbian but as "queer," is developing a perspective of sexual orientation more complex and fluid than what has historically been viewed along rigid lines. This new construction of sexuality, combined with the antiquated, unscientific hypotheses on which conversion therapy has been based, render traditional reorientation therapy anachronistic.

The lack of empirical support for conversion therapy calls into question the judgment of clinicians who practice or endorse it. The APA "Fact Sheet on Reparative Therapy" opens with the following statement: "No scientific evidence exists to support the effectiveness of any of the conversion therapies that try to change sexual orientation." A review of the literature makes it obvious why this statement is made. Psychologists are obliged to use methods that have some empirically demonstrable efficacy, and there is a paucity of such evidence relative to conversion therapy. Moreover, there is a need to understand fully the potentially damaging effects of a failed conversion treatment.

A next logical question, then, involves standards of practice for the treatment of lesbians and gay men that *are* compatible with scientific data. In 1991, the APA's Committee on Lesbian and Gay Concerns published the results of a survey on bias in psychotherapeutic treatment of lesbians and gay men. This survey is an initial step in providing the clinician with guidelines that are consistent with science and that promote the welfare and dignity of the gay or lesbian individual. More research is needed to refine these recommendations for the myriad of issues that gay people bring to therapy. It is the responsibility of psychologists to provide accurate scientific information, particularly as so much misinformation is currently being used to further stigmatize and justify, even legislate, discrimination against gay people. The current wave of antigay political activity is founded on the mistaken assumptions that homosexuality is a chosen way of life and an abnormal one at that. It may be impossible to understand why so many people would believe that lesbians and gay men would deliberately choose a way of life that puts them at risk for discrimination and violence. It is, however, well within psychology's purview to disseminate accurate information from our considerable database about homosexuality.

Even more significant than the practical considerations of conversion therapy are the ethical concerns. Psychologists are obliged to use methods that promote the dignity and welfare of humankind. Conversion therapies fail in this regard because they are necessarily predicated on a devaluation of homosexual identity and behavior. Some contemporary conversionists would claim a value-neutral stance, insisting that conversion therapy is simply a matter of the client's right to choose treatment, but what is the purpose of attempting to change sexual orientation if it is not negatively valued? How many dissatisfied heterosexual men and women seek a similar conversion to homosexuality? What message does psychology send to society when it affirms the normalcy of homosexuality yet continues to give tacit approval to efforts to change it? Murphy, summarizing his review of the conversion therapy literature, addressed this:

> There would be no reorientation techniques where there was no interpretation that homoeroticism is an inferior state, an interpretation that in many ways continues to be medically defined, criminally enforced, socially sanctioned, and religiously justified. And it is in this moral interpretation, more than in the reigning medical theory of the day, that all programs of sexual reorientation have their common origins and justifications. (1992, p. 520)

This morality is at work in all aspects of homophobic activity, from the alarming increase in violent hate crimes against gay men and lesbians to the political and legislative agendas of antigay organizations. Perpetrators of violence and antigay political groups justify their actions with the same devaluation of homosexuality that is used by conversion therapists.

Given the extensive societal devaluation of homosexuality and lack of positive role models for gay men and lesbians, it is not surprising that many gay people seek to become heterosexual. Homophobic attitudes have been institutionalized in nearly every aspect of our social structure, from the government and the military to our educational systems and organized religions. For gay men and lesbians who have identified with the dominant group, the desire to be like others and to be accepted socially is so strong that heterosexual relating becomes more than an act of sex or love. It becomes a symbol of freedom from prejudice and social devaluation. Psychology cannot free people from stigma by continuing to promote or tacitly endorse conversion therapy. Psychology can only combat stigma with a vigorous avowal of empirical truth. The appropriate focus of the profession is what reverses prejudice, not what reverses sexual orientation.

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Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents

Children and adolescents who are growing up gay, lesbian, bisexual, gender nonconforming, or gender discordant experience unique developmental challenges. They are at risk for certain mental health problems, many of which are significantly correlated with stigma and prejudice. Mental health professionals have an important role to play in fostering healthy development in this population. Influences on sexual orientation, gender nonconformity, and gender discordance, and their developmental relationships to each other, are reviewed. Practice principles and related issues of cultural competence, research needs, and ethics are discussed. J. Am. Acad. Child Adolesc. Psychiatry, 2012;51(9):957–974. **Key Words:** sexual orientation, homosexuality, bisexuality, gender identity disorder, gender discordant.

Scientific studies demonstrating the healthy, adaptive functioning of the great majority of gay and lesbian adults paved the way toward removal of homosexuality as an illness from the *DSM* in 1973.[1] Homosexuality is now recognized as a nonpathological variant of human sexuality. Although the great majority of gay and lesbian individuals have normal mental health, as a group they experience unique stressors and developmental challenges. Perhaps in part as a consequence of these challenges, adult and adolescent members of sexual minorities (defined below) develop depression, anxiety disorders, substance abuse, and suicidality at rates that are elevated in comparison with those in the general population.[2,3] Thus, psychosocial distress may account for the different rates in depression, hopelessness, and current suicidality seen between gay, lesbian, and bisexual adolescents and their heterosexual peers.[4] Studies in the U.S. and the Netherlands document this problem continuing into adulthood, and show a significant association among stigma, prejudice, discrimination, and poor mental health.[2,5,6]

Sexual development comprises biological, psychological, and social aspects of experience. Extensive scientific research, described below, has been conducted on the influence of these factors on sexual orientation and gender in recent years. Much of what has been learned scientifically about sexual orientation and gender development in the last generation has occurred in parallel with societal changes in attitudes toward sexual orientation and gender roles. While bias against sexual minorities is declining in many segments of society, intolerance is still widespread. Children and adolescents are exposed to these negative attitudes and are affected by them. This Practice Parameter is intended to foster clinical competence in those caring for children and adolescents who are growing up to be gay, lesbian, bisexual, gender variant, or transgender, reflecting what is currently known about best clinical practices for these youth.

METHODOLOGY

The list of references for this Practice Parameter was developed by online searches of Medline and PsycINFO. A search of PsycINFO articles published since 1806 and Medline articles published from 1950 through April 27, 2010, of key-word terms "sexual orientation," "gay," "homosexuality," "male homosexuality," "lesbianism," "bisexuality," "transgender," "transsexualism," "gender variant," "gender atypical," "gender identity disorder," and "homosexuality, attitudes toward" limited to English language, hu-

man subjects, and ages 0–17 years (PsycINFO) or 0–18 years (Medline) produced 7,825 unique and 967 duplicate references.

To take full advantage of the MeSH Subject Headings database, a subsequent search was conducted of articles in the Medline database through May 3, 2010 using MeSH Subject Headings terms "homosexuality," "male homosexuality," "female homosexuality," "bisexuality," "transsexualism," and limiting articles to those written in English and related to human subjects, all child and adolescent ages (0–18 years). This search produced 2,717 references.

Similarly, to take full advantage of the Thesaurus Terms (Descriptors) database, a subsequent search was conducted of articles in the PsycINFO articles through May 14, 2010 using Thesaurus Terms (Descriptors) "sexual orientation," "homosexuality," "male homosexuality," "female homosexuality," "lesbianism," "bisexuality," "transgender," "transsexualism," "gender identity disorder," and "homosexuality (attitudes toward)" and limiting articles to those written in English and related to human subjects of childhood age (0–12) and adolescent age (13–17). This search produced 1,751 references.

The combined search in Medline MeSH Subject Headings and PsycINFO Thesaurus Terms (Descriptors) databases produced 4,106 unique references and 361 duplicate references. Of the 4,106 unique references, the following were winnowed out: 345 books or book sections; 94 dissertation abstracts; 18 editorials; 13 articles whose focus was primarily historical; 104 theoretical formulation or comment without peer review; 163 case reports or brief series; 32 related primarily to policy or law; 19 related to news; 74 related primarily to research methods; 736 primarily about human immunodeficiency virus (HIV)/acquired immune deficiency sydrome (AIDS) and an additional 404 about early HIV/AIDS or other sexually transmitted illness; one each related to an award, book review, or interview; 168 that dealt primarily with diseases, reproduction, paraphilia or intersex conditions beyond the scope of the Parameter; an additional 8 that fell outside the specified age range; an additional 26 duplicates that were found; and 10 dating from 1960 to 1975 related to aversive or "reparative" techniques intended to change sexual orientation that are inconsistent with current ethical position statements of the American Psychiatric Association.[7] This winnowing process yielded 1,889 references.

To help ensure completeness of the search strategies, the search results using Medline MeSH terms and PsycINFO Thesaurus terms (Descriptors) were compared to key-word terms of the Medline and PsycINFO databases. This comparison demonstrated 1,113 overlapping references, with 6,712 unique to the key-word search and 2,993 unique to the combined Thesaurus Term (Descriptor) and MeSH searches.

An updated Medline search of articles through March 3, 2011, of the MeSH database using the same Subject Headings and limits used in the previous search produced 138 references. An updated PsycINFO search of articles through March 3, 2011, of the Thesaurus database using the same Terms (Descriptors) and limits used in the previous search produced 107 references.

Throughout the search, the bibliographies of source materials including books,[8-10] book chapters,[11] and review articles.[12-14] were consulted for additional references that were not produced by the online searches. Bibliographies of publications by the following experts were also examined to find additional pertinent articles not produced by online searches: Jennifer I. Downey, M.D., Jack Drescher, M.D., Richard C. Friedman, M.D., Gilbert Herdt, Ph.D., Richard Isay, M.D., Ellen Perrin, M.D., Heino F. L. Meyer-Bahlburg, Dr. rer. nat., Gary Remafedi, M.D., M.P.H., and Kenneth Zucker, Ph.D. Recent studies and discussions at scientific meetings in the past decade were considered for inclusion.

From the list of references assembled in this way, references were selected whose primary focus was mental health related to sexual orientation, gender nonconformity, and gender discordance in children and adolescents. References that were not a literature review, published in peer-reviewed literature, or based on methodologically sound strategies such as use of population-based, controlled, blinded, prospective, or multi-site evidence were eliminated. References were selected that illustrated key points related to clinical practice. When more than one reference illustrated a key point around which there is general consensus, preference was given to those that were more recent, relevant to the U.S. population, most illustrative of key clinical concepts, based upon larger samples, prospective study design, or meta-analysis. When discussing issues around which consensus is not yet established,

citations illustrating a representative sample of multiple viewpoints were selected.

DEFINITIONS

Many terms related to sexual development are being continually updated. The following definitions reflect current terminology, and are used in this Practice Parameter.

- *Sex*, in the sense of being male or female, refers to a person's anatomical sex. (Although usually considered dichotomously male or female, disorders of sex development can lead to intersex conditions, which are beyond the scope of this Practice Parameter).
- *Gender* refers to the perception of a person's sex on the part of society as male or female.
- *Gender role behavior* refers to activities, interests, use of symbols, styles, or other personal and social attributes that are recognized as masculine or feminine.
- *Gender identity* refers to an individual's personal sense of self as male or female. It usually develops by age 3, is concordant with a person's sex and gender, and remains stable over the lifetime. For a small number of individuals, it can change later in life.
- *Identity* refers to one's abstract sense of self within a cultural and social matrix. This broader meaning (equivalent to ego identity) is distinct from gender identity, and usually consolidated in adolescence.
- *Sexual orientation* refers to the sex of the person to whom an individual is erotically attracted. It comprises several components, including sexual fantasy, patterns of physiological arousal, sexual behavior, sexual identity, and social role.
  - *Homosexual* people are attracted erotically to people of the same sex, and are commonly referred to as gay in the case of males, and gay or lesbian in the case of females.
  - *Heterosexual* people are attracted erotically to people of the other sex.
  - *Bisexual* people are attracted erotically to people of both sexes.
- *Sexual minority* refers to homosexual and bisexual youth and adults.
- *Sexual prejudice* (or more archaically, *homophobia*) refers to bias against homosexual people. "Homophobia" is technically not a phobia; like other prejudices, it is characterized by hostility and is thus a misnomer, but the term is used colloquially.[15]
- *Internalized sexual prejudice* (or colloquially, *internalized homophobia)* is a syndrome of self-loathing based upon the adoption of anti-homosexual attitudes by homosexual people themselves.
- *Heterosexism* refers to individual and societal assumptions—sometimes not explicitly recognized—promoting heterosexuality to the disadvantage of other sexual orientations.
- *Childhood gender nonconformity* refers to variation from norms in gender role behavior such as toy preferences, rough-and-tumble play, aggression, or playmate gender. The terms *gender variance* and *gender atypicality* have been used equivalently in the literature.
- *Gender discordance* refers to a discrepancy between anatomical sex and gender identity. The term *gender identity variance* has been used to denote a spectrum of gender-discordant phenomena in the literature.
  - *Transgender* people have a gender identity that is discordant with their anatomical sex.
  - *Transsexuals* are transgender people who make their perceived gender and/or anatomical sex conform with their gender identity through strategies such as dress, grooming, hormone use and/or surgery (known as *sex reassignment*).
- *Gender minority* refers to gender nonconforming and gender-discordant children, adolescents, and adults.

HOMOSEXUALITY

Homosexuality comprises multiple components, and can refer to several aspects of same-sex attraction, including physiological arousability, erotic fantasy, sexual behavior, psychological identity, or social role. These facets of homosexuality can be congruent or incongruent in any given person.[9,16] Many men and women with homosexual desire suppress their feelings or behavior, agonize over sexual orientation, or have homosexual relationships they keep secret while maintaining a heterosexual public identity.

Not surprisingly, rates of homosexuality vary depending upon definition and study method. In one study, adult males reported same-sex experience rates of 2.7% for the past year, 4.9% since age 18 years, and approximately 7–9% since puberty; for women, rates were 1.3%, 4.1%, and approximately 4%, respectively.[16] Homosexual-

ity was correlated with higher education and urban residence. In another study, rates of lifetime same-sex experience were 6.7% for men and 14.2% for women, and 3% of men and 4% of women reported a same-sex partner in the preceding 12 months.[17]

One large sample of predominantly white but geographically and socioeconomically diverse junior and senior high school students found that 10.1% of males and 11.3% of females were "unsure" of their sexual orientation, and 1.5% of males and 1.1% of females said they were "bisexual or predominantly homosexual." Same-sex attractions were reported by 4.5% of males and 5.7% of females, same-sex fantasies by 2.2% of males and 3.1% of females, and same-sex sexual behavior by 1.6% of males and 0.9% of females. Of youth with homosexual experience, only 27.1% identified themselves as gay, consistent with a struggle with identity and group affiliation.[18]

Influences on Sexual Orientation

There is evidence that biological factors influence sexual orientation.[19] Evidence from a variety of animal and human studies indicate that prenatal neuroendocrine factors, including levels of sex hormones, influence sexual organization of the brain in utero when neuronal patterns are laid down, and activate their sexual function beginning in puberty.

Neuroendocrine Factors. The *neurohormonal theory* of sexual orientation posits that prenatal sex hormone levels influence development of gender role behavior in childhood and sexual orientation in adulthood.[20] However, evidence of the organizing effects of sex hormones in females, and of the degree to which animal studies may be relevant to humans is limited.[21] Although sex hormone levels during fetal brain development may influence childhood gender variance and adult sexual orientation, neither homosexuality nor gender variance is an indication for endocrine, genetic, or any other special medical evaluation.

Genetic Factors. There is evidence of a genetic influence on gender role behavior in childhood and sexual orientation in adulthood from family, twin, and molecular studies.[19] One study found that, among gay adult males, 52% of monozygotic co-twins were homosexual, whereas only 22% of dizygotic co-twins and 11% of adoptive brothers were homosexual.[22] Another study found that, among adult lesbians, 48% of monozygotic co-twins, 16% of dizygotic co-twins, and 6% of adoptive sisters were also lesbian.[23] These data suggest a substantial heritable influence on sexual orientation.

Neuroanatomy. Limited evidence suggests that the size of certain neuroanatomical features may correlate with sexual orientation. In males, these may include the third anterior interstitial nucleus of the hypothalamus (INAH-3)[24] and the suprachiasmatic nucleus (SCN).[19] Further research is needed to confirm these results and to establish their significance. When used appropriately, information about biological influences on sexual orientation can be relevant to patients, families, and clinicians. However, such influences do not constitute an illness.

Psychological and Social Factors. Before the shift to empirically based psychiatry following the publication of *DSM-III*, prevailing psychiatric theory ascribed homosexuality to character pathology.[1] However, this view was revised because of a lack of empirical evidence. Although homosexuality is associated with somewhat elevated rates of certain psychiatric disorders such as depression and anxiety, there is no evidence from any controlled scientific study that most gay and lesbian people suffer from character pathology, or from any other mental illness; on the contrary, the vast majority do not.[2,3] In addition, studies of character profiles and defense mechanisms have found no differences between nonheterosexuals and the general population.[25,26] Another theory, that male homosexuality resulted from overly close mothers and hostile or distant fathers, was similarly not supported by empirical study of nonclinical populations.[27] Rather, nonclinical groups of gay adults, especially males, appear to have childhood histories of gender nonconformity; their family relationships may be the result rather than the cause of gender nonconformity, and may possibly be subject to a degree of recall bias.[28,29]

Social learning does not appear to influence sexual orientation at the level of erotic fantasy or physiological arousal, although it can influence identity and social role in both positive and negative ways. Knowledge of other homosexual people is not necessary for the development of a homosexual orientation.[9] The effect of parents'

sexual orientation on their children's own gender development and sexual orientation has been investigated in longitudinal studies of community samples in the U.S. and the United Kingdom.[30-33] Parents' sexual orientation had no effect on gender development in general. This was true even though tolerance for gender nonconformity was more common among lesbian parents than among heterosexual ones. Boys raised by lesbian couples demonstrated greater gender role flexibility such as helping with housework, on average, a social strength that was also observed in some heterosexual-parent families, and that appears to be influenced more by parental attitudes than by parental sexual orientation. Regarding sexual orientation in adolescents who were raised by same-sex parents (including same-sex attraction, same-sex relationships, and gay identity), compared with the general population, no differences in sexual attraction are found; the large majority of adolescents raised by lesbian couples identify as heterosexual. However, in the minority of cases, when they do experience same-sex attractions, adolescent girls raised by lesbian parents appear to experience less stigma about acting on those feelings than those raised by heterosexual parents, and are accordingly slightly more likely to identify as bisexual.[33] Data on children raised by gay male couples is relatively lacking, but preliminary evidence appears to be consistent with the findings in children raised by lesbian couples.[30]

Exposure to anti-homosexual attitudes can induce shame and guilt in those growing up gay, leading them to suppress a gay identity or same-sex behavior; conversely, well-adjusted gay or lesbian adults can provide positive role models for youth.[7] There is no rational basis for depriving gay youth of such role models, as stereotyped views of homosexual adults as being more likely to commit sexual abuse of minors is not supported by evidence.[34,35]

Psychosexual Development and Homosexual Orientation

Children display aspects of sexuality from infancy, and develop sexual feelings almost universally by adolescence or earlier. Although most people are predominantly heterosexual, some develop predominantly same-sex attractions and fantasies in or before adolescence. Most boys, whether heterosexual or homosexual, experience a surge in testosterone levels and sexual feelings in puberty, and almost all begin to masturbate then.[36] Most girls experience more gradually increasing sexual desires. A majority of girls, although a smaller majority than among boys, also begin to masturbate, and they do so over a broader age range. Erotic fantasizing often accompanies masturbation, and may crystallize sexual orientation.[37] Whether heterosexual or homosexual, most men experience more frequent interest in sex and fantasies involving explicit sexual imagery, whereas women's sexual fantasies more often involve romantic imagery.[38] Sexual behavior with others typically begins in or after mid-to-late adolescence, although the age of onset of activity, number of partners, and practices vary greatly among individuals.[16]

One possible developmental pathway of male homosexuality proceeds from same-sex erotic fantasy to same-sex experience, then homosexual identity (self-labeling as gay), and finally a homosexual social role (identifying oneself as gay to others).[39] In comparison with those who first identify as gay in adulthood, those who identify as gay in adolescence may be somewhat more likely to self-label as gay before same-sex experience, and to achieve the foregoing gay developmental milestones earlier. This developmental path appears to be more common in recent cohorts than it once was,[40] perhaps reflecting the consolidation of a gay identity earlier in recent generations as the result of the increasing visibility of gay role models for adolescents. Developmental pathways may be more variable in females, whose sexuality is generally more fluid than that of males.[41] Compared with men, women are more likely to experience homosexual as well as heterosexual attraction across the lifespan.[12] This may occur only in youth, may emerge in adulthood, or may be stable through life.[42]

Certainty about sexual orientation and identity—both gay and straight—increases with age, suggesting "an unfolding of sexual identity during adolescence, influenced by sexual experience and demographic factors."[18] Although it may be difficult to tell which developmental path a particular adolescent is on at a given moment, a consistently homosexual pattern of fantasy, arousal, and attraction suggests a developmental path toward adult homosexuality. Retrospectively, many gay men and lesbians report same-sex erotic attraction from youth onward.[28]

Development of Gender Role Behavior. Boys and girls generally exhibit different patterns of gender role behavior. These are quite distinct from erotic feelings, instead involving such areas as toy preferences, play patterns, social roles, same-sex or opposite-sex peer preferences, gesture, speech, grooming, dress, and whether aggression is expressed physically or through social strategies.[43,44] For example, most boys are more likely than girls to engage in rough-and-tumble play. Most boys exhibit aggression physically, whereas most girls do so through verbal and social means. When given a choice, most boys are more likely to select conventionally masculine toys such as cars, trains, and adventure or fighting games, whereas most girls more frequently select conventionally feminine toys such as dolls, jewelry, and nurturing games. Most children exhibit a preference in middle childhood for same-sex playmates, or "sex-segregated play."

Social, psychological, and biological factors, including genetic and environmental ones, interactively influence childhood gender role behavior and gender identity.[45,46] Sex differences exist at multiple levels of brain organization, and there is evidence of neuroanatomic differences between gender-typical and gender-atypical individuals. At the same time, part of a developing child's cognitive understanding of gender—for example, whether competitiveness and aggression can be feminine, or whether empathic, nurturing activities can be masculine—is related to societal norms.[47] As science has progressed, the complexity of the way in which factors related to gender role behavior such as genes, hormones, and the environment (including the social environment) interact have come to be better appreciated. Psychological experience is presumably reflected in brain structure or function, and each may influence the other. Previous questions about the roles of nature and nurture in causing childhood gender role differences have come to be understood as overly simplistic, and have been replaced by models showing biological and environmental factors influencing one another bidirectionally during critical periods in neurodevelopmental processes that are sometimes modifiable and sometimes fixed.

Gender Nonconformity and Its Developmental Relationship to Homosexuality. Most boys and girls display some variability in gender role behavior. However, some children display toy, play, and peer preferences that are typical of the other gender. They have been referred to as "gender atypical," "gender variant," or, increasingly, "gender nonconforming" in scholarly literature. Childhood gender nonconformity often is a developmental precursor of homosexuality in males, and sometimes in females.[48]

Although childhood gender nonconformity does not predict adult homosexuality with certainty, many gay men recall boyhood aversion to rough-and-tumble play, aggressive behavior, and competitive athletics.[49] In females, gender nonconformity (e.g., being a "tomboy") is sometimes associated with adult homosexual orientation, although less consistently than in males.[50] Many gay people report having felt "different" from others long before the development of erotic feelings as such due to childhood gender nonconformity, which can elicit teasing, low peer status, and poor self-esteem; boys, who may particularly value adherence to gender norms, may be especially distressed.[51]

Although gender nonconforming children may experience discomfort or marked anxiety if forced to participate in gender-typical behaviors, their gender identity is entirely congruent with their sex. They do not express a wish to be, or belief they are, the other sex. On the contrary, gender nonconforming boys in particular may be upset by feelings they are insufficiently masculine, especially in contexts in which gender norms are highly valued.[9]

Adolescence, Sexual Orientation, and Identity Formation. Adolescence normally brings increased sexual and aggressive drives, social role experimentation, and separation and individuation for all youth. For those who are developing as gay, lesbian, bisexual, or transgender, the challenge of establishing one's ego identity—including a sense of one's sexual identity—is uniquely complex. Although most heterosexual youth take social acceptance of their sexual orientation for granted, sexual and gender minority youth usually cannot.[9] They must cope with feeling different, ostracism, and dilemmas about revealing a sexual identity that is discrepant from family and social expectations ("coming out").[13] These adolescents are at somewhat elevated risk for having suicidal thoughts[52-54]; however, only a minority actually do, indicating a capacity for resilient coping in most.

Increasing social acceptance may encourage gay, lesbian, or bisexual adolescents to come out more frequently and at younger ages. However, some youth who become aware that they have homosexual feelings may be unprepared to cope with possible negative attitudes that they may encounter among their own family or peers.[55]

Clinical Issues in Homosexuality

Effects of Stigma, Peer Rejection, Bias, and Bullying. Despite increasing tolerance, gender and sexual minority youth may experience criticism, ostracism, harassment, bullying, or rejection by peers, family, or others, even in relatively tolerant, cosmopolitan settings.[56] These can be associated with significant social problems, distress, and psychological symptoms.[57] They may be shunned or disparaged when they long for peer acceptance. A poor developmental fit between children's gender nonconformity or sexual orientation and parents' expectations can result in distress for both parent and child.[11]

Internalized Sexual Prejudice. Even when not personally threatened, homosexual youths may be indirectly or overtly disparaged by family or peers. They may observe other gay people experiencing disrespect, humiliation, lower social status, or fewer civil rights. This experience may create difficulty reconciling the simultaneous developmental needs to form a sexual identity on the one hand and to feel socially acceptable on the other, typically a painful developmental conflict for gay youth.[13] They may identify with others who are emotionally important to them but sexually prejudiced, leading to a syndrome of self-loathing (internalized sexual prejudice, or "internalized homophobia"). This may adversely affect self-esteem, lead to denial of same-sex attractions, cause difficulty identifying with other gay people, and prevent formation of healthy relationships.[8]

Revealing a Homosexual Orientation to Others. Many gay and lesbian youth hide their identity from others.[55] The dilemma over whether to reveal a homosexual orientation—to "come out of the closet" or "come out"—is a unique aspect of the psychological development of sexual and gender minority youth. They must decide whether to hide their sexual orientation (remain "in the closet," or "closeted") or risk rejection. Coming out is usually a highly significant event that may be anticipated with dread. There is no single answer to the question whether a particular gay youth should come out, or to whom. This requires judgment about the youth's maturity and coping, as well as the social context. For some, coming out brings great relief. Others in hostile environments may come out with bravado before it is safe; for them, remaining closeted or in denial may be adaptive.

GENDER IDENTITY AND GENDER DISCORDANCE

For the vast majority of people, gender identity is established in toddlerhood, is consistent with biological sex, and remains fixed. This holds true for many children with gender-nonconformity in toy, play, and playmate preferences. However, some children experience not only gender nonconformity, but also discomfort with their biological sex. They derive comfort from being perceived as, or a wish to be, the other sex. The desire leads to discordance between gender identity and phenotypic sex, a core feature of gender identity disorder (GID) as conceptualized in the *DSM-IV*.[58] The diagnosis of GID in children is controversial, and the degree to which *DSM-IV* criteria reflect an illness or social bias against gender nonconformity has been debated.[59,60]

Several different categories of gender discordance, each characterized by a unique developmental trajectory, have been described.[61] They differ in regard to whether gender discordance emerges in childhood, adolescence or adulthood; whether the gender discordance is persistent or transient; and whether there is a post-transition homosexual or heterosexual orientation. These heterogeneous developmental trajectories may subsume different causes of gender discordance.

In follow-up studies of prepubertal boys with gender discordance—including many without any mental health treatment—the cross gender wishes usually fade over time and do not persist into adulthood, with only 2.2%[62] to 11.9%[63] continuing to experience gender discordance. Rather, 75% become homosexual or bisexual in fantasy and 80% in behavior by age 19; some gender-variant behavior may persist.[63] The desistence of gender discordance may reflect the resolution of a "cognitive confusion factor,"[64] with increasing flexibility as children mature in thinking about gender identity and realize that one

can be a boy or girl despite variation from conventional gender roles and norms.

In contrast, when gender variance with the desire to be the other sex is present in adolescence, this desire usually does persist through adulthood.[65] This gender discordance may lead to life-long efforts to pass socially as the other sex through cross-dressing and grooming, or to seek sex reassignment through hormones or surgery.

Many of the clinical issues pertaining to gay and lesbian youth doubtlessly affect youth with gender discordance as well. In addition, children and especially adolescents with gender discordance have been found to have behavior problems and anxiety.[66,67] Proposed causes include family and social opprobrium, the discrepancy between psychological and anatomic gender, and maternal and family psychopathology.[65,68]

Factors Influencing Development of Gender Discordance

Causes of gender discordance may include biological factors.[59] Genetic males with gender discordance tend to have a later birth order, more male siblings, and lower birth weight, suggesting an influence of prenatal events that is poorly understood. Individuals with gender discordance may differ in central nervous system lateralization from the general population. Consistent with this hypothesis, they are more likely to be non-righthanded, to have abnormal EEG findings, and to have lateral otoacoustic processing consistent with their gender identity compared to a non-gender discordant population.[59] As with sexual orientation, variations in prenatal sex hormones may influence later gender identity, but do not appear to fully determine it.[69] There is evidence that the central bed nucleus of the stria terminalis (BSTc), a hypothalamic structure implicated in sexual behavior, is small in male to female transsexuals, similar to most females.[70]

A hypothesis that inappropriately close maternal and overly distant paternal relationships causes gender discordance in boys was not borne out by empirical study, which found both mothers and fathers to be distant from sons with gender discordance, possibly a result, rather than the cause, of gender discordance.[62] A theory that predisposing biological factors, temperamental anxiety, and parental tolerance for gender nonconformity interact to cause gender discordance has not been empirically tested.[71] A controlled study found increased rates of psychopathology in mothers of boys with gender discordance, but was not designed to assess a causal relationship.[68]

PRINCIPLES

Principle 1. A comprehensive diagnostic evaluation should include an age-appropriate assessment of psychosexual development for all youths.

The psychiatric evaluation of every patient should take into consideration psychosexual development in a way that is appropriate to developmental level and the clinical situation. Questions about sexual feelings, experiences, and identity or about gender role behavior and gender identity can help clarify any areas of concern related to sexuality. The history should be obtained in a nonjudgmental way, for example without assuming any particular sexual orientation or implying that one is expected. This can be conveyed, for example, by the use of gender-neutral language related to the aim of affection (e.g., asking "is there someone special in your life?" rather than "do you have a boyfriend/girlfriend?") until the adolescent reveals a particular sexual orientation.

Sexual and gender minority adolescents very frequently face unique developmental challenges, as described above. If an initial screen indicates that issues of sexual orientation, gender nonconformity, or gender identity are of clinical significance, these challenges can be explored in greater depth.

Principle 2. The need for confidentiality in the clinical alliance is a special consideration in the assessment of sexual and gender minority youth.

Issues of confidentiality are important with all patients; they are particularly so with sexual and gender minority youth, who require a clinical environment in which they can explore their developing orientation and identity. Prior experiences of rejection and hostility may lead them to watch social cues vigilantly to determine whether they can safely reveal their sexual orientation to others without fear of bias or judgment. Any sign of these in a mental health professional may induce shame and undermine the clinical alliance.

Clinicians should bear in mind potential risks to patients of premature disclosure of sexual

orientation, such as family rejection or alienation from support systems, which might precipitate a crisis. They should be familiar with standard confidentiality practices for minors, and should protect confidentiality when possible to preserve the clinical alliance. This is particularly true when using media such as electronic health records, in which sensitive information can be easily disseminated. It is often helpful to emphasize reasonable expectations of privacy in the clinical relationship with sexual and gender minority youth—not to express shame, but to permit the exploration of sexual identity free from fear and with a sense of control over disclosure. As the development of sexual identity is variable, it is often desirable to allow youth to set the pace of self-discovery.

Principle 3. Family dynamics pertinent to sexual orientation, gender nonconformity, and gender identity should be explored in the context of the cultural values of the youth, family, and community.

Families of sexual or gender minority youth may consult mental health professionals for a variety of reasons, for example, to ask whether a disclosure of being gay represents a temporary stage, to request support for an adolescent, or to address problems such as bullying, anxiety, or depression. Just as some adults try to alter their sexual orientation,[72] some parents may similarly hope to prevent their children from being gay. Difficulty coping with prejudice and stigma are often the appropriate focus of treatment.

Families treat gay or gender-discordant children with considerable variation. Whereas some accept their children, others explicitly or implicitly disparage or reject them, evoking shame and guilt; some force them to leave home. Although some are surprised by a child's coming out, others are not, and some are supportive. Families may have to fundamentally alter their ideas about a child who comes out, confront misconceptions, and grieve over lost hopes and/or expectations. Most parents experience distress following a child's coming out, frequently experiencing cognitive dissonance or feelings of anxiety, anger, loss, shame, or guilt; despite this, over time the majority become affirming and are not distressed.[73] Children frequently predict their parents' reactions poorly. Ideally, families will support their child as the same person they have known and loved, although doing so may require time.

Youth who are rejected by their parents can experience profound isolation that adversely affects their identity formation, self-esteem, and capacity for intimacy; stigmatized teens are often vulnerable to dropping out of school, homelessness (which may lead to exploitation or heightened sexual risk), substance abuse, depression and suicide.[53] Clinicians should aim to alleviate any irrational feelings of shame and guilt, and preserve empathic and supportive family relationships where possible. They should assess parents' ideas about what constitutes normal, acceptable behavior, their cultural background, and any misconceptions or distorted expectations about homosexuality. These may include fears that their child will have only casual relationships, is fated to contract HIV/AIDS, cannot become a parent if desired, or will be ostracized. Stereotyped views of gay males as engaging only in numerous, indiscriminate sexual encounters are not supported by empirical research except in rare cases.[12] If such behavior is present and cannot be explained as part of normal adolescent sexual drive or identity formation, factors known to be associated with excessive sexuality in youth, such as a history of sexual abuse, family dysfunction, a pattern of conduct problems, or mood disorder such as bipolar disorder or depression, should be considered. Clinicians should screen for all forms of abuse or neglect (as in any evaluation), with careful attention to adverse family reactions to a youth's sexual or gender development. If these are suspected, they should involve child protective services as clinical appropriateness and ethical and legal mandates warrant. Support groups may be helpful for families in distress. In cases of protracted turmoil or family pathology, referrals to family therapy, individual or couples therapy may be appropriate.

Sexual and gender minority youth may experience unique developmental challenges relating to the values and norms of their ethnic group.[74] Various groups may place different emphasis on ideals of masculinity or femininity, on family loyalty, or on social conformity; some with authoritarian parenting ideals may sanction youth who reject traditional mores.

For gay and lesbian adolescents who are also members of ethnic minorities, the deleterious effect of anti-homosexual bias may be compounded by the effect of racial prejudice. In

response to unique pressures to gain group acceptance, they may give particular weight to negative group stereotyping of gay people. Gay and lesbian youth who are also members of ethnic minorities may be less likely than nonminority youth to be involved in gay-related social activities, to be comfortable with others knowing they are gay, or to disclose a gay identity.[75] In caring for youth who are members of both ethnic and sexual minorities, mental health professionals should take into account the unique complexities of identity formation for these groups.

Religion, often a valued aspect of identity, can vary widely regarding tolerance for sexual minorities. Membership in relatively more liberal or conservative religious groups is a significant influence on one's "sexual script," or social pattern in the expression of sexuality.[16] Some minority denominations hold strong religious injunctions against homosexuality and stricter views about gender roles. As a result, members of certain religious groups can experience special challenges in integrating their sexual identity with family and community values. However, many religious groups are reconciling their traditions with more inclusive values. This remains an area of active social and cultural debate and change. Clinicians should respect the religious values of their patients, and should be aware of ongoing developments in religious thinking that may provide opportunities to integrate the religious and sexual aspects of identity.

Principle 4. Clinicians should inquire about circumstances commonly encountered by youth with sexual and gender minority status that confer increased psychiatric risk.

Bullying. Gay, lesbian, bisexual, and gender nonconforming youth are regularly exposed to hostile peers. Victims of peer harassment experience serious adverse mental health consequences including chronic depression, anxiety, and suicidal thoughts.[76-78] Sexual and gender minority youth may benefit from support for coping with peer harassment. School programs including no-tolerance policies for bullying have proved effective.[79] Family treatment may be useful when sexual and gender minority youth are harassed in their families. Psychotherapy may help to avert or alleviate self-loathing related to identification with the aggressor. Clinicians should consider environmental interventions such as consultation or advocacy with schools, police, or other agencies and institutions advocating enforcement of zero tolerance policies to protect youth who may be victims of harassment or bullying.

Suicide. Rates of suicidal thoughts and suicide attempts among gay, lesbian, and gender-variant youth are elevated in comparison with the general population.[52-54] The developmental interval following same-sex experience but before self-acceptance as gay may be one of especially elevated risk.[54] Suicidal thoughts, depression, and anxiety are especially elevated among gay males who were gender-variant as children.[80,81] Family connectedness, adult caring, and school safety are highly significant protective factors against suicidal ideation and attempts.[82]

High-Risk Behaviors. Unique factors promoting risk-taking among gay and lesbian youth include maladaptive coping with peer, social and family ostracism, emotional and physical abuse, and neglect.[83] Fear of rejection may lead some youth to be truant, run away, become homeless, be sexually exploited, or become involved in prostitution. Positive coping skills and intact support systems can act as protective factors. Lesbian youth have higher rates of unintended pregnancy than heterosexual female youth, perhaps due to anxiety about their same-sex attractions and a desire to "fit in," an assumption birth control is unnecessary, or high-risk behavior rooted in psychological conflict.[84] Clinicians should monitor for these risks or provide anticipatory guidance for them when appropriate.

Substance Abuse. Some adolescents explore a gay identity in venues such as dance clubs and bars where alcohol and drugs are used. These youth may be at heightened risk of substance abuse because of peer pressure and availability of drugs. Lesbian and bisexual girls and boys describing themselves as "mostly heterosexual" (as opposed to unambiguously hetero- or homosexual) are at increased risk for alcohol use.[85] A subgroup of gay youth displays higher rates of use of alcohol and drugs including marijuana, cocaine, inhalants, designer, and injectable drugs.[52] They may use drugs and alcohol to achieve a sense of belonging or to relieve painful affects such as shame, guilt, and a lack of confidence associated with their romantic and sexual feelings.

HIV/AIDS and Other Sexually Transmitted Illnesses. Adolescents are at risk for acquiring sexually transmitted illnesses included HIV infection through sexual risk taking, especially those who feel invulnerable or fatalistic, or who lack mature judgment, self-confidence, or the mature interpersonal skills needed to negotiate safe sexual experiences. Programs aimed at reducing adolescent sexual risk taking that are successful not only increase information about how HIV and sexually transmitted diseases are acquired and prevented, but also provide emotionally relevant and practical help in having safe sexual experiences that are developmentally relevant to youth.[86] Adolescent gay males may be at particular risk of acquiring HIV sexually because of its high prevalence among men who have sex with men. Factors such as substance abuse or internalized homophobia associated with shame, guilt, or low self-esteem may interfere with an individual's motivation to use knowledge effectively about how to protect oneself from acquiring HIV infection. If present, these issues should be addressed clinically. Special HIV-prevention programs have been developed for and tested in gay youth and have demonstrated promising results.[87,88]

Principle 5. Clinicians should aim to foster healthy psychosexual development in sexual and gender minority youth and to protect the individual's full capacity for integrated identity formation and adaptive functioning.

Protecting the opportunity to achieve full developmental potential is an important clinical goal in working with sexual and gender minority youth. The psychological acceptability of homosexual feelings to an individual and his or her family, and the individual's capacity to incorporate them into healthy relationships, can change with therapeutic intervention, and are an appropriate focus of clinical attention.[9] Clinicians should strive to support healthy development and honest self-discovery as youth navigate family, peer, and social environments that may be hostile. Family rejection and bullying are often the proper focus of psychiatric treatment rather than current or future sexual orientation.

Sometimes questions about a youth's future sexual orientation come to psychiatric attention. When they do, it may be most useful to explore what this issue means to the adolescent and significant persons in his/her life. It may be preferable to indicate that it is too early to know an adolescent's sexual orientation rather than to refer to such feelings as a "phase," which may have connotations of disapproval.

When working clinically with youth whose sexual orientation or gender identity is uncertain, protecting the opportunity for healthy development without prematurely foreclosing any developmental possibility is an important goal. Clinicians should evaluate and support each child's ability to integrate awareness of his or her sexual orientation into his or her sexual identity while developing age-appropriate capacities in the areas of emotional stability, behavior, relationships, academic functioning, and progress toward an adult capacity for work, play, and love.

The availability of role models for sexual and gender minority youth varies greatly. The increasing visibility of gay people in society may decrease the isolation and loneliness of some gay youth, but others may be confronted with information that forces self-labeling before they are able to cope with irrational bias and feeling different. Some have access to positive role models or opportunities to form an affirming sexual identity among family, friends, the media, or through school programs such as gay–straight alliances. Urban environments or the Internet may give youth access to positive role models and experiences, but may also carry risks that require adult supervision.

Principle 6. Clinicians should be aware that there is no evidence that sexual orientation can be altered through therapy, and that attempts to do so may be harmful.

There is no established evidence that change in a predominant, enduring homosexual pattern of development is possible. Although sexual fantasies can, to some degree, be suppressed or repressed by those who are ashamed of or in conflict about them, sexual desire is not a choice. However, behavior, social role, and—to a degree—identity and self-acceptance are. Although operant conditioning modifies sexual fetishes, it does not alter homosexuality.[89] Psychiatric efforts to alter sexual orientation through "reparative therapy" in adults have found little or no change in sexual orientation, while causing significant risk of harm to self-esteem.[7] A study of efforts to do so in adults[71] has been criticized for failure to adequately consider risks such as increased anguish, self-loathing, depression, anxiety, sub-

stance abuse and suicidality, and for failure to support appropriate coping with prejudice and stigma.[90]

There is no empirical evidence that adult homosexuality can be prevented if gender nonconforming children are influenced to be more gender conforming. Indeed, there is no medically valid basis for attempting to prevent homosexuality, which is not an illness. On the contrary, such efforts may encourage family rejection and undermine self-esteem, connectedness, and caring, which are important protective factors against suicidal ideation and attempts.[82] As bullies typically identify their targets on the basis of adult attitudes and cues,[76] adult efforts to prevent homosexuality by discouraging gender variant traits in "pre-homosexual children" may risk fomenting bullying. Given that there is no evidence that efforts to alter sexual orientation are effective, beneficial, or necessary, and the possibility that they carry the risk of significant harm, such interventions are contraindicated.[7,91]

Principle 7. Clinicians should be aware of current evidence on the natural course of gender discordance and associated psychopathology in children and adolescents in choosing the treatment goals and modality.

A majority of children display gender role behavior that adult caregivers regard as departing from gender role norms in toy preferences at least some of the time (demonstrating a difference between that which is culturally expected and that which is actually statistically normal).[92] However, a smaller group of children demonstrate a consistent difference in gender role behavior from social norms. In different children, this may be true to varying degrees. In some, it may involve only a few areas—for example, an aversion to rough-and-tumble sports in boys, or tomboyishness in girls. In others, it may involve several areas, including dress, speech, and use of social styles and mannerisms. It is important to distinguish those who display only variation in gender role behavior (gender nonconformity, which is not a *DSM* diagnosis) from those who also display a gender identity discordant from their socially assigned birth gender and biological sex (gender discordance, reflected in the *DSM-IV* diagnosis Gender Identity Disorder when accompanied by marked gender nonconformity).[93]

A clinical interview using *DSM* criteria is the gold standard for making a *DSM* diagnosis. In some cases of gender role variance, there may be clinical difficulty distinguishing between gender nonconformity and gender discordance—for example, there may be clearly marked gender nonconforming behavior, but ambiguous cross-sex wishes. To assist clinicians in determining whether gender discordance is present, in addition to using clinical interviews, they can consider using structured instruments such as the Gender Identity Interview for Children,[94] the Gender Identity Questionnaire for Children,[95] and the Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults.[96] In using such instruments, clinicians should bear in mind that the American Psychiatric Association's Gender Identity Disorder subworkgroup for *DSM-5* is currently debating areas of controversy in the diagnostic criteria for GID, including whether and how the explicit verbalization of gender discordant wishes should be included as a criterion, given the difficulty children may have expressing such wishes in nonaccepting environments.[93]

Disorders of sex development are an important differential diagnosis in gender discordant children and adolescents, for which endocrinological treatment may be indicated.[97] When the clinical history suggests that a somatic intersex condition may be present, clinicians should consider consultation with a pediatric endocrinologist or other specialist familiar with these conditions.

Children. Different clinical approaches have been advocated for childhood gender discordance. Proposed goals of treatment include reducing the desire to be the other sex, decreasing social ostracism, and reducing psychiatric comorbidity.[14] There have been no randomized controlled trials of any treatment. Early treatments for gender discordance developed in the 1970s included behavioral paradigms[98]; their long-term risks and benefits have not been followed up in controlled trials, and have been rejected on ethical grounds as having an inappropriately punitive and coercive basis.[99] Psychodynamically based psychotherapy for gender discordance in boys has been proposed based on a psychodynamic hypothesis that gender discordance is a defense in fantasy against profound, early separation anxiety[71]; like other treatment strategies, this has not been empirically tested in controlled trials.

Recent treatment strategies based upon uncontrolled case series have been described that focus on parent guidance and peer group interaction. One seeks to hasten desistence of gender discordance in boys through eclectic interventions such as behavioral and milieu techniques, parent guidance and school consultation aimed at encouraging positive relationships with father and male peers, gender-typical skills, and increased maternal support for male role-taking and independence.[100] Another approach encourages tolerance of gender discordance, while setting limits on expression of gender-discordant behavior that may place the child at risk for peer or community harassment.[101] Desistence of gender discordance has been described in both treatment approaches, as it is in untreated children.

As an ethical guide to treatment, "the clinician has an obligation to inform parents about the state of the empiric database,"[14] including information about both effectiveness and potential risks. As children may experience imperatives to shape their communications about gender discordant wishes in response to social norms, a true change in gender discordance must be distinguished from simply teaching children to hide or suppress their feelings. Similarly, the possible risk that children may be traumatized by disapproval of their gender discordance must be considered. Just as family rejection is associated with problems such as depression, suicidality, and substance abuse in gay youth,[57] the proposed benefits of treatment to eliminate gender discordance in youth must be carefully weighed against such possible deleterious effects.

Given the lack of empirical evidence from randomized, controlled trials of the efficacy of treatment aimed at eliminating gender discordance, the potential risks of treatment, and longitudinal evidence that gender discordance persists in only a small minority of untreated cases arising in childhood, further research is needed on predictors of persistence and desistence of childhood gender discordance as well as the long-term risks and benefits of intervention before any treatment to eliminate gender discordance can be endorsed.

There is similarly no data at present from controlled studies to guide clinical decisions regarding the risks and benefits of sending gender-discordant children to school in their desired gender. Such decisions must be made based on clinical judgment, bearing in mind the potential risks and benefits of doing so. Social gender assignment appears to exert partial influence on the gender identity of infants with disorders of sex development.[69] At the same time, countervailing biological factors may override social gender assignment and contribute significantly to gender discordance in many cases. Therefore, the possibility that sending a child to school in his/her desired gender may consolidate gender discordance or expose the child to bullying should be weighed against risks of not doing so, such as distress, social isolation, depression, or suicide due to lack of social support. Further research is needed to guide clinical decision making in this area.

Adolescents. For some individuals, discordance between gender and phenotypic sex presents in adolescence or adulthood.[102] Sometimes it emerges in parallel with puberty and secondary sex characteristics, causing distress leading to a developmental crisis. Transgender adolescents and adults often wish to bring their biological sex into conformity with their gender identity through strategies that include hormones, gender correction surgery, or both, and may use illicitly obtained sex hormones or other medications with hormonal activity to this end. They may be at risk from side effects of unsupervised medication or sex hormone use.

One goal of treatment for adolescents in whom a desire to be the other sex is persistent is to help them make developmentally appropriate decisions about sex reassignment, with the aim of reducing risks of reassignment and managing associated comorbidity.[14] In general, it is desirable to help adolescents who may be experiencing gender distress and dysphoria to defer sex reassignment until adulthood, or at least until the wish to change sex is unequivocal, consistent, and made with appropriate consent. Transgender youth may face special risks associated with hormone misuse, such as short- and long-term side effects, improper dosing, impure or counterfeit medications, and infection from shared syringes.

For situations in which deferral of sex-reassignment decisions until adulthood is not clinically feasible, one approach that has been described in case series is sex hormone suppression under endocrinological management with psychiatric consultation using gonadotropin-releasing hormone analogues that reversibly delay the

development of secondary sexual characteristics.[102] The goals of such treatment are to avoid distress caused by unwanted secondary sexual characteristics, to minimize the later need for surgery to reverse them, and to delay the need for treatment decisions until maturity allows the adolescent to participate in providing informed consent regarding transition to living as the other sex. Prospective, case-controlled study of such treatment to delay puberty has shown some beneficial effects on behavioral and emotional problems, depressive symptoms, and general functioning (although not on anxiety or anger), and appears to be well tolerated acutely.[103] In addition, gender discordance is associated with lower rates of mental health problems when it is treated in adolescence than when it is treated in adulthood.[104] Therefore, such treatment may be in the best interest of the adolescent when all factors, including reducing psychiatric comorbidity and the risk of harm from illicit hormone abuse, are considered.

Treatment approaches for GID using guidelines based on the developmental trajectories of gender-discordant adolescents have been described.[105-107] In one approach, puberty suppression is considered beginning at age 12, cross-sex hormone treatment is considered beginning at age 16, and gender reassignment surgery at age 18.[105] Gender reassignment services are available in conjunction with mental health services focusing on exploration of gender identity, cross-sex treatment wishes, counseling during such treatment if any, and treatment of associated mental health problems. In another approach based on stage of physical development rather than age, pubertal suppression has been described at Tanner stage 2 in adolescents with persistent GID; risks requiring management include effects on growth, future fertility, uterine bleeding, and options for subsequent genital surgery and cross-sex hormone use.[107] For families of transgender adolescents, a therapeutic group approach has been described that encourages parental acceptance.[108] This approach may help to mitigate psychopathology and other deleterious effects of environmental nonacceptance. Further research is needed to definitively establish the effectiveness and acceptability of these treatment approaches.

Principle 8. Clinicians should be prepared to consult and act as a liaison with schools, community agencies, and other health care providers, advocating for the unique needs of sexual and gender minority youth and their families.

Evaluating youths' school, community, and culture—essential in any psychiatric evaluation—is particularly important for sexual and gender minority youth. Clinicians should seek information about the sexual beliefs, attitudes, and experiences of these social systems, and whether they are supportive or hostile in the patient's perception and in reality. Clinicians should not assume that all parties involved in a youth's social system know about his or her sexual identity. They should review with the youth what information can be shared with whom, and elicit concerns regarding specific caregivers. If appropriate, the clinician can consider interventions to enhance support, with the youth's knowledge and assent.

As consultants, mental health professionals can help to raise awareness of issues affecting sexual and gender minority youth in schools and communities, and advise programs that support them. Clinicians can consider advocating for policies and legislation supporting nondiscrimination against and equality for sexual and gender minority youth and families, and the inclusion of related information in school curricula and in libraries.

Principle 9. Mental health professionals should be aware of community and professional resources relevant to sexual and gender minority youth.

Many community-based organizations and programs provide sexual and gender minority students with supportive, empowering experiences safe from stigma and discrimination (e.g., the Harvey Milk School at the Hetrick Martin Institute, www.hmi.org; Gay Straight Alliances, www.gsanetwork.org).

There are many books and Internet resources for youth and families on issues such as discovering whether one is gay or lesbian. Clinicians should consider exploring what youth and families read, and help them to identify useful resources. Organizations such as Parents, Friends, and Families of Lesbians and Gays (PFLAG, www.pflag.org) and the Gay, Lesbian and Straight Education Network (GLSEN) provide support and resources for families, youth, and educators. These organizations have programs in a number of communities. Clinicians can obtain information through professional channels such

as the AACAP Sexual Orientation and Gender Identity Issues Committee (www.aacap.org), the American Psychiatric Association (www.psych.org), the Lesbian and Gay Child and Adolescent Psychiatric Association (www.lagcapa.org), and the Association for Gay and Lesbian Psychiatrists (www.aglp.org).

The Model Standards Project, published by the Child Welfare League of America, is a practice tool related to the needs of LGBT youth in foster care or juvenile justice systems available at www.cwla.org.[109] The *Standards of Care for Gender Identity Disorders*, including psychiatric and medical care, are published by the World Professional Association for Transgender Health (www.wpath.org).[110]

PARAMETER LIMITATIONS

AACAP Practice Parameters are developed to assist clinicians in psychiatric decision making. These Parameters are not intended to define the sole standard of care. As such, the Parameters should not be deemed inclusive of all proper methods of care or exclusive of other methods of care directed at obtaining the desired results. The ultimate judgment regarding the care of a particular patient must be made by the clinician in light of all of the circumstances presented by the patient and that patient's family, the diagnostic and treatment options available, and other available resources. &

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AACAP develops both patient-oriented and clinician-oriented Practice Parameters. Patient-oriented Parameters provide recommendations to guide clinicians toward best assessment and treatment practices. Recommendations are based on the critical appraisal of empirical evidence (when available) and clinical consensus (when not), and are graded according to the strength of the empirical and clinical support. Clinician-oriented Parameters provide clinicians with the information (stated as principles) needed to develop practice-based skills. Although empirical evidence may be available to support certain principles, principles are based primarily on clinical consensus. This Parameter is a clinician-oriented Parameter.

The primary intended audience for the AACAP Practice Parameters is child and adolescent psychiatrists; however, the information contained therein may also be useful for other mental health clinicians.

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EDITORIAL

Regulations Restrict Practice of Conversion Therapy

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In February, 2016, New York's Governor, Andrew Cuomo, became the first US governor to take executive action to restrict the practice of conversion therapy.[1] Four US states,[2–5] the District of Columbia,[6] and the province of Ontario, Canada[7] have restricted the practice legislatively. Conversion therapy, also referred to as reparative therapy,[i,8–10] originally referred to interventions aimed at changing an individual's sexual orientation; however, the language of recent regulations defines it as interventions aimed at changing not only sexual orientation, but also gender identity and gender expression.[5,6,11] Malta is currently considering a bill to ban the therapy and if it passes it will be the first European country to do so.[12]

Conversion therapy often targets adolescents who lack the legal authority to make medical decisions on their own behalf. As long as they are minors, they may have no choice but to submit to the wishes of their parents or guardians. The first awareness of same-sex attractions usually occurs in adolescence; however, the integration of those attractions into one's sense of self and identity as a gay, lesbian, or bisexual person often does not occur for several years after that first awareness, and sometimes never occurs. The resistance to accepting oneself as a member of a stigmatized minority contributes to this delay.[13] Similarly, an average delay of 9 years elapses between a youth's first awareness of gender incongruence and divulging it to parents.[14]

Although each sexual and gender minority (SGM) population experiences a unique profile of health risks and disparities, increased rates of depression, anxiety disorders, suicidality, and substance abuse have been found across all groups and are linked to stigma.[15] The support of and acceptance by family and friends can buffer this stigma and they are important factors for the mental health and wellbeing of LGBT youth.[16,17] When such support is not available, SGM youths often must deal with the stigma alone. By signaling that sexual and gender variance are unacceptable, and should be changed, conversion therapies reinforce stigma and add to the mental health burden of SGM individuals.

The American Academy of Pediatrics, the American Psychiatric Association, the American Psychological Association, the National Association of Social Workers, and other leading medical and mental health associations have denounced conversion therapies.[18] The consensus opinion of the medical professions is that these therapies lack demonstrated efficacy in achieving their goals, which are, themselves, questionable from an ethical perspective, and are associated with numerous negative outcomes, including lowered self-esteem, self-hatred, depression, and suicidality.[18–20]

In April, 2015, after the suicide of a transgender teenager who had been subjected to conversion therapy, the Obama administration urged individual states to ban the therapy.[21] Three states (California, Oregon, and New Jersey) and the District of Columbia had previously passed legislation protecting children from the therapy and Illinois passed similar legislation shortly after. More than 20 additional states have introduced similar bills.[18] In February, 2016, after a bill to restrict the therapy had been stalled in the New York State legislature for close to 2 years,[1] Governor Cuomo took executive action to prohibit public and private healthcare insurers from covering the practice in New York and to prohibit state mental health facilities from using it with minors.[22] *LGBT Health* applauds Governor Cuomo for taking this important action and encourages the governors of other states to examine the evidence and consider similar action.

Legislation aimed at restricting the practice of conversion therapies must be carefully worded to avoid restricting legitimate practices, and practitioners in jurisdictions with such legislation should familiarize themselves with its stipulations. Approximately 6 months after Ontario banned conversion therapy in 2015, the Child Youth and Family Gender Identity Service of its Centre for Addiction and Mental Health was closed amid allegations that it practiced conversion therapy.

[i]The terms ''conversion therapy'' and ''reparative therapy'' are sometimes used interchangeably, however, reparative therapy is a subset of conversion therapies based on the premise that same-sex attractions are reparations for childhood trauma.[8] Thus, practitioners of reparative therapy believe that exploring, isolating, and repairing these childhood emotional wounds will often result in reducing same-sex attractions.[9,10]

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The Ontario clinic's treatment of gender dysphoria in children and adolescents, and its rationale are clearly spelled out elsewhere.[23,24] Recognizing that a child's stated gender identity may change without intervention as she/he matures, the clinic employed a model of initial treatment with preadolescent patients that, at least initially, took a neutral rather than a gender-affirming approach with the aim of helping children to ''feel comfortable in their own skin.''[23] It is often assumed that premature support of social gender transition could increase the odds of persistence or create problems for minors who subsequently desire transition back to their originally assigned gender.[24,25] For various reasons (e.g., social stigma, likelihood of requiring hormonal and surgical procedures with their associated risks and costs), persistence is sometimes considered to be an undesirable outcome.[24] While this view of persistence may not necessarily reflect a negative valuation of transsexuality, per se, a negative judgment of transsexuality is, nevertheless, implicit in the desire to prevent it. In addition to providing clinical services, the clinic conducted research to identify childhood predictors of persistence and desistence to guide future clinical practice and was widely regarded as one of the premier gender clinics for children and adolescents internationally.

In contrast to its initial approach with children, the clinic generally took an affirming approach with adolescents whose cross-gender identification had persisted from childhood, providing psychological support and education for the adolescent and caregivers, pubertal suspension, and appropriately timed induction of puberty consistent with the adolescent's experienced gender.[24] With new onset of gender dysphoria during adolescence, however, before affirmation, the clinic took a more cautious approach to first rule out the possibility that the desire to be a different gender was in response to trauma (e.g., a girl who expresses the desire to be a boy to escape sexual abuse) or an epiphenomenon of mental illness.[24] While cautiously delaying gender affirmation is not without its own set of risks as discussed by Laura Jacobs et al. in this issue, delaying affirmation should not be construed as conversion therapy or an attempt to change gender identity. At this time, the scientific and medical communities have not yet reached consensus regarding the appropriate treatment of prepubescent children with gender dysphoria. This lack of consensus regarding the appropriate treatment of prepubescent children with gender dysphoria is discussed in the 2011 Report of the APA Task Force on the Treatment of Gender Identity Disorder.[24] Closure of the Ontario clinic before making alternative provisions for gender-variant children and adolescents has left a void for many needing its services.

In other recent developments, on February 2, 2016, the City Council of the District of Columbia unanimously approved a law mandating two credit hours per cycle in LGBT cultural competency for all healthcare providers who are required to receive continuing medical education (CME) to renew their licenses.[26] This will make DC the first jurisdiction to mandate such CME, although in 2014 the state of California passed legislation recommending that CME ''include, as appropriate, information pertinent to the appropriate treatment of, and provision of care to, the lesbian, gay, bisexual, transgender, and intersex communities.''[27] The DC legislation is a step in the right direction to increase the LGBT cultural competency of licensed health professionals in its jurisdiction.

The recent surge of efforts to achieve equity in healthcare for SGM individuals has been particularly strong for those who are transgender. To assure the expeditious publication of meritorious research to address the specific healthcare needs of transgender individuals, Mary Ann Liebert, Inc. launched *Transgender Health* in January 2016. *Transgender Health* is a peer-reviewed open access journal that publishes under the continuous publication model. Articles are published online within 4 weeks of acceptance, which facilitates rapid communication and wide dissemination of promising findings. The journal overview, manuscript submission guidelines, and articles published to date, can be found on the journal's website at www.liebertpub.com/overview/transgender-health/634/. The editor-in-chief is Robert Garofalo, MD, MPH, who is professor of Pediatrics-Adolescent Medicine and Preventive Medicine at Northwestern University Feinberg School of Medicine. Dr. Garofalo has a distinguished record of leadership, research, and clinical practice in LGBT health.

The current issue of *LGBT Health* contains diverse articles that address various aspects of health and healthcare in SGM populations. A perspective article by Sean Cahill and colleagues reviews the importance of routine recording of sexual orientation and gender identity data in clinical settings. The authors also provide an update on progress toward implementing the collection of these data, including the recent requirement for electronic health record technology certified under Meaningful Use to include fields for recording the data. In a second perspective, Patrick Herron addresses the ethical implications of and social stigma associated with pre-exposure prophylaxis use for HIV prevention.

Among the original research articles and short reports is a particularly noteworthy article by George Brown and Kenneth Jones. It is the first study to examine a large cohort of transgender patients ($N = 5135$) for psychiatric and medical health outcome disparities using longitudinal medical record data with a matched control group. The study finds global disparities in both psychiatric and medical diagnoses. Mohamed Jaffer and colleagues describe an intervention that successfully improved transgender healthcare in the New York City correctional system. Sarah Palazzolo and colleagues explore the effects of documentation status as a contextual determinant of HIV risk among young transgender Latinas living in the United States. Judith Bradford and colleagues examine healthy aging in a community for older lesbians and Sidra Zaidi and colleagues present the first health data on women who have sex with women in Kenya.

In a letter to the editor, commenting on a recent article by Jacobs et al. that addressed gender transition in individuals with autism spectrum disorders,[28] John Parkinson raises concerns about premature affirmation of transgender identity in these individuals and mentions the case of an assigned male whose pleas for feminizing hormones were deferred for several years after which he decided that his identity was not feminine after all. Laura Jacobs et al. respond by asking how long it should take for such a client to demonstrate their readiness to transition and whether desistance after prolonged deferrals may reflect succumbing to negative messaging implicit in such delays.

We encourage our readers to participate in our mission and invite you to submit your original research, reviews, and perspective articles to *LGBT Health*. We give priority to scholarship that can be put into action to improve the health of SGM populations in any region of the globe, including

those where LGBT and other SGM individuals lack legal protection from persecution. We also invite comments on recent content, in the form of letters to the editor, and suggestions for the most salient topics and pressing issues to be addressed in the journal. We have recently published two highly successful special issues, one devoted to the health of sexual minority women, and the other devoted to cancer in SGM populations. Future special issues are planned to address the health of SGM youth and SGM aging. We are also seeking high-quality original articles and reviews in areas of priority for health research on LGBT and other SGM populations and on topics relevant to health promotion and disease prevention, early detection, and treatment.

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ORIGINAL RESEARCH—INTERSEX AND GENDER IDENTITY DISORDERS

The Treatment of Adolescent Transsexuals: Changing Insights

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ABSTRACT

Introduction. Treatment of individuals with gender identity disorder (GID) has in medicine nearly always met with a great deal of skepticism. Professionals largely follow the Standards of Care of the World Professional Association for Transgender Health. For adolescents, specific guidelines have also been issued by the British Royal College of Psychiatrists.

Aim. To describe the stepwise changes in treatment policy which, in recent years, have been made by the team of the Gender Identity Clinic at the VU University Medical Center in Amsterdam, The Netherlands.

Methods. The first step taken to treat adolescents was that, after careful evaluation, (cross-sex hormone) treatment could start between the ages of 16 and 18 years. A further step was the suppression of puberty by means of gonadotropin-releasing hormone analogs in 12–16 year olds; the latter serves also as a diagnostic tool. Very recently, other clinics in Europe and North America have followed this policy.

Results. The first results from the Amsterdam clinic show that this policy is promising.

Conclusions. Professionals who take responsibility for these youth and are willing to help should yet be fully aware of the impact of their interventions. In this article, the pros and cons of the various approaches to youngsters with GID are presented, hopefully inciting a sound scientific discussion of the issue. **Cohen-Kettenis PT, Delemarre-van de Waal HA, and Gooren LJG. The treatment of adolescent transsexuals: Changing insights. J Sex Med 2008;5:1892–1897.**

Key Words. Transsexualism; Gender Identity Disorder; Sex Reassignment; Gender Dysphoria; GnRH Analogs; Adolescents

Introduction

Sex reassignment for individuals with gender identity disorder (GID), often called transsexuals, has in medicine nearly always met with a degree of skepticism and equivocation [1–5]. McHugh [5], for example, stated that he found it hard to understand how the belief of a man "that he is a woman trapped in a man's body differs from the feelings of a patient with anorexia nervosa that she is obese despite her emaciated, cachectic state. We don't do liposuction on anorexics. So why amputate the genitals of these patients?" (p. 111). Rather than seen as a way to relief psychic pain, sex reassignment is regarded as "tampering" with the integrity of a healthy body. Such views are even more outspoken when it comes to the treatment of young people. It is felt that, if ever, only in adulthood gender identity is sufficiently consolidated to allow for decisions regarding invasive, and irreversible interventions such as hormonal and surgical therapy [2].

With the state of the art medicine in 2008, the (patho-) biological basis of GID is still poorly

understood, and its diagnosis relies totally on psychological methods. Research on post mortem brains of male-to-female transsexuals (MtFs) and one female-to-male transsexual (FtM) has demonstrated that one of the sex-dimorphic brain nuclei, the central part of the bed nucleus of the stria terminalis, shows all characteristics of opposite—sex differentiation [6,7]. Unfortunately, these brain structures are too small in size to visualize with presently available imaging techniques of the brain, and the (temporal) relationship between the development and size of these brain structures and the development of a GID is far from clear. This implies that the diagnosis of GID still relies on a subjective report of a person verified by a mental health professional using diagnostic criteria as spelled out in the widely used psychiatric classification system Diagnostic and Statistical Manual of Mental Disorders IV-TR [8]. Because of the far-reaching nature of the interventions, professionals largely follow the Standards of Care [9] of the World Professional Association for Transgender Health, formerly called the Harry Benjamin International Gender Dysphoria Association. For adolescents, specific guidelines also exist of the British Royal College of Psychiatrists [10]. In both guidelines, the diagnostic process is lengthy and takes place in several stages. This is important because 80–95% of the prepubertal children with GID will no longer experience a GID in adolescence [11–13]. First, there is a diagnostic phase in which the actual diagnosis of GID is made, and an estimation is made of potential risk factors for post-treatment regret. Then, during a phase called the "real life test" or "real life experience," both clinician and patient check whether the applicant is able to live satisfactorily in the desired gender role. Only if the real life experience had been successful, the applicant will be eligible for sex reassignment surgery (SRS).

Some find a diagnostic process as described, especially for young applicants, a less than solid foundation for a medical intervention impinging on the physical integrity of the body [2]. They refer to classical medical ethical adages such as "in dubio abstine" (when in doubt, abstain from intervention) and "primum non nocere" (first, do no harm). For a long time, health professionals have waited till their patients have reached young adulthood, or, in general, the age of legal consent to medical treatment, even though these adolescents make very clear that they find their pubertal physical changes unbearable.

Besides the professional consideration that the condition can only be diagnosed with certainty in adulthood (see also below), some health care providers might also fear disapproval of the peer group, reactions of the correctional medical boards, or litigation.

Changes in Policy

The Amsterdam VU university medical center treats 98% of the Dutch transsexuals. About 20 years ago, when a few adolescents with an overwhelming and clear-cut GID came to the attention of clinicians [14], the decision was taken to start the sex reassignment (SR) procedure before adulthood. Despite many years of psychotherapy, gender dysphoria had not abated in these youngsters. Many of the problems they were struggling with seemed to be the consequence rather than the cause of their GID. They were very lucid about their situation, had no psychopathology that would obtrude their self-assessment, and were able to cope with the process of transitioning to the other sex. There was also strong parental support for the treatment decision. This convinced us to make a change in policy and we decided to treat subjects younger than 18 years hormonally. Males were treated with anti-androgens first and with estrogens a few months later provided they appeared to do well; females were treated first with progesterone to stop menstrual bleeding and androgens later [15]. The minimum age set then for this treatment was 16 years. Although, in the Netherlands, adolescents are from the age of 16 years on legally competent to make decisions on their medical treatment, parents were required to endorse the request for treatment, which always was the case. Parents had been involved in the earlier diagnostic process and were of the conviction that hormonal and subsequent surgical treatment was the only acceptable solution to alleviate the suffering of their child.

In several studies this protocol has been evaluated [16–18]. From these studies it appeared that the youth who were selected for early hormone treatment (starting between 16 and 18 years) no longer suffered from gender dysphoria, and that 1–5 years after surgery, they were socially and psychologically functioning not very different from their peers. Their scores on various psychological instruments, such as a shortened Dutch form of the Minnesota Multiphasic Personality Inventory and the Symptom Check List-90 [19], were considerably more favorable than scores of a group of

subjects who had been treated in adulthood in the Amsterdam clinic, and scores were in the normal range as compared to normative samples. By contrast, there was also a cohort of adolescents presenting with gender dysphoria, who after long-term assessment (which, depending on the degree of gender dysphoria and nonrelated pathology, could take a year or even longer) were not deemed eligible for early treatment, and they did not pursue SR at later ages. So, the burden of the GID, the unabating pursuit of SR, and clinical assessment provided by our clinic appeared to provide acceptable selection criteria for good candidates for SR before adulthood. Over the last 5–6 years the age of adolescents applying for SR has dropped considerably. It is no longer unusual to have 12-year-olds presenting at gender identity clinics with the wish to undergo SR. Most are accompanied and supported by their parents. These youngsters are no longer willing to wait for many years, knowing that the alienating experience of development of the secondary sex characteristics of their biological sex by then will have been completed and can only be incompletely reversed at a high price of medical interventions. Clinics with a good deal of experience with gender dysphoric juveniles such as in Gent, Boston, Oslo, and Toronto recently started to offer (or refer for) medical interventions before the age of 16 years provided hormonal puberty has started, and has progressed to at least Tanner stage 2. Other criteria for a start with gonadotropin-releasing hormone (GnRH) analogs are: (i) a presence of gender dysphoria from early childhood on; (ii) an increase of the gender dysphoria after the first pubertal changes; (iii) an absence of psychiatric comorbidity that interferes with the diagnostic work-up or treatment; (iv) adequate psychological and social support during treatment; and (v) a demonstration of knowledge and understanding of the effects of GnRH, cross-sex hormone treatment, surgery, and the social consequences of sex reassignment. Treatment consists of administration of GnRH analogs blocking the hormonal puberty of their biological sex. No cross-sex hormones are administered at this stage. In our view, these early hormonal interventions should not be considered as sex reassignment per se. Their effects are reversible. By blocking, delaying or "freezing" puberty by means of GnRH analogs time is "bought" [20]. The peace of mind of the adolescent provides more opportunity to explore with the mental health professional the applicant's wish for SR thoroughly. The prospect of the alienating experience of developing sex characteristics, which they do not regard as their own, will not occur. It is also proof of solidarity of the health professional with the plight of the applicant. Yet many professionals are reluctant to treat youth with GID with GnRH analogs. They reason that before a GID can be regarded as unremitting, the brain must have been fully exposed to the hormones of puberty of the sex one is born in. There is, however, no evidence from brain research to support this contention.

Arguments Pro-Pubertal Delay

There are a number of reasons for allowing adolescents to start with the GnRH analogs.

First, delaying the start of treatment (even under 16 years) has its psychological drawbacks. Some individuals who have shown a pattern of extreme cross-sex identification from toddlerhood onwards develop psychological problems, such as depression, suicidality, anorexia, or social phobias, which are consequences of the agony about the pubertal physical development rather than comorbidity unrelated to the GID. This burden can adversely affect social and intellectual development. Patients and their parents often report that halting the physical features of puberty is an immediate relief of the patients' suffering.

Second, pubertal suppression may give adolescents, together with the attending health professional, more time to explore their gender identity, without the distress of the developing secondary sex characteristics. The precision of the diagnosis may thus be improved.

Third, the child who will live permanently in the desired gender role as an adult may be spared the torment of (full) pubescent development of the "wrong" secondary sex characteristics (e.g., a low voice and male facial features for the ones who will live as women, and breasts and a short stature [males are on average 12 cm taller than women] for the ones who will live as men). This is obviously an enormous and life-long disadvantage. Ross and Need [21] found that postoperative psychopathology was primarily associated with factors that made it difficult for transsexuals to pass postoperatively successfully as members of their new sex. If the adolescents would make a social gender change without receiving hormone treatment, they may fail to be perceived by others as a member of the desired sex and be easy targets for harassment or violence.

Fourth, early treatment will likely make certain forms of surgery redundant or less invasive (e.g., breast reduction in FtMs and maxillo-facial surgery in MtFs).

Fifth, follow-up studies among adult transsexuals show that unfavorable postoperative outcome seems to be related to a late rather than an early start of the sex reassignment procedure (for reviews, see [22–24]). Age at time of assessment also emerged as a factor differentiating two groups of MtFs with and without postoperative regrets [25].

Sixth, youth who have no access to regular treatment may try to find illicit sources of medication (Internet and older peers) and turn away from any professional health care all together.

There is increasing evidence that GID is not a matter of choice or caused (solely) by environmental factors, such as poor parenting. We are still far from understanding which factors are necessary or sufficient for an atypical gender identity development [26]. Biological factors do seem to play a role [6,7,27–29] and may contribute to persistent GID (see below).

Arguments Against Pubertal Delay

Some assume that it is not possible to make a definitive diagnosis of GID in adolescence, because in this developmental phase gender identity is still fluctuating; others fear that preventing secondary sex characteristics to develop will inhibit a "spontaneous formation of a consistent gender identity, which sometimes develops through the 'crisis of gender'" (see also [30]). These points raise the question of what is actually known about the persistence of GID in juveniles. If childhood GID does not persist over time it would be less than desirable to provide early somatic treatment. As mentioned earlier, symptoms of GID at prepubertal ages decrease or even disappear in a considerable percentage of children (estimates range from 80–95%) [11,13]. Therefore, any intervention in childhood would seem premature and inappropriate. However, GID persisting into early puberty appears to be highly persistent [31]: at the Amsterdam gender identity clinic for adolescents, none of the patients who were diagnosed with a GID and considered eligible for SR dropped out of the diagnostic or treatment procedures or regretted SR [16–18]. Even some of those who were not eligible to start treatment before the age of 18 years because of serious psychiatric comorbidity, extremely adverse living circumstances, or a combination of both, persisted in their wish for SR. Because their other problems had to be addressed before they were regarded eligible to start SR successfully, their treatment was usually delayed until after 18 years of age.

Another potential risk of blocking pubertal development relates to the development of bone mass and growth, both typical events of hormonal puberty, and of brain development. In theory, peak bone mass may not be achieved and/or there might be body segment disproportion. However, the first data of a Dutch cohort of adolescents who have been treated with GnRH analogs suggest that, after an initial slowing in bone maturation, it significantly caught up after the commencement of cross-sex steroid hormone treatment [32]. A parallel may be drawn with children with a (constitutionally) delayed puberty who are similarly exposed to sex steroids beyond the normal age of puberty. There are indications that these children develop a lower bone mineral density than children who go through puberty at a normal age but the differences are not large [33]. It has also been reported that these differences might be attributed to the methods of measuring properties of bone [33,34]. Body proportions, as measured by sitting height and sitting-height/height ratio, remained in the normal range [32]. Early treatment may result in a final height for MtFs that is in the normal female range. For FtMs, a timely administration of oxandrolone may result in acceptable male height [32]. Effects of suppression of the hormones of puberty on brain development are currently studied, and not known yet. Clinically, there seem to be no effects on social, emotional, and school functioning, but potential effects may be too subtle to observe during the follow-up sessions by clinical assessment alone.

Finally, for the MtFs a non-normal pubertal phallic growth, the genital tissue available for vaginoplasty may be less than optimal. However, appropriate adjusted techniques exist to deal with the shortage of tissue [35].

Ethical and Legal Aspects

Are adolescents able to make their own decisions when it comes to medical treatment? According to Dutch law, adolescents from 16 years on are legally competent to make a treatment choice, even without parental consent, because it is assumed that they are able to fully understand the pros and cons of a treatment. These, and possible alternative treatments, should have been explained

completely and repeatedly to the patient in the course of the diagnostic procedure. Under Dutch law, if children are between 12 and 16, they can also make treatment decisions, but at this age they still need the consent of their parents.

Some argue that it is not possible to give valid informed consent to hormonal suppression of puberty, because the risks of it are partially unpredictable. Giordano [30] points out that if it were impossible to consent to interventions whose outcome is uncertain, much medical research involving human beings would be unethical. Indeed, much research is done *because* the outcome is not known. Naturally, in order to give valid consent, the applicant must receive as complete as possible information about treatment, and has to be informed about the unknown risks of each stage of therapy. The person will then consider and weigh the unknown risks of treatment and the potential benefits on one side, and all the known psychological and physical effects of nontreatment on the other. It will be clear that in the case of a complex treatment such as SR, informed consent is not given at a single point in time. Rather, it is a process during which the adolescent is progressively more able to understand what the decision is all about.

Finally, in judging the desirability of hormonal pubertal suppression as a first but reversible phase in the sex reassignment procedure, one should not only take consequences of the intervention into account. Rather, one should also consider the consequences of nontreatment. Nonintervention is not a neutral option, but has clear negative lifelong consequences for the quality of life of those individuals who had to wait for treatment until after puberty. It may lead to irresponsible and risky, unhealthy actions of the patient in order to get access to the desired medication, distrust against professionals, with negative consequences for other aspects of their health care. It may lead to developmental arrest, and a psychological functioning forever hampered by shame about one's appearance. This implies that "in dubio abstine" may actually be harmful. Not different from other endeavors in medicine, the care for gender dysphoric juveniles must be open to peer review and scientific scrutiny, which has always featured high on the agenda of the Dutch health care for transgendered subjects.

Realizing the potential harmfulness of nonintervention, one may wonder whether not providing treatment may not only be doubtful on ethical grounds, but also have legal implications [36].

In the field of treatment of young adolescents, it may be that the adage "in dubio abstine" needs to be reconsidered. Particularly when there are research opportunities to lessen this "dubium" to the benefit of those who suffer from gender dysphoria.

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Making Gender Identity Disorder of Childhood: Historical Lessons for Contemporary Debates

Karl Bryant

Abstract: Gender Identity Disorder of Childhood (GIDC)—a psychiatric diagnosis given to gender-variant children—has been controversial since its creation. Critics inside and outside of the mental health professions have called for the removal or revision of GIDC, arguing that it has served to pathologize homosexuality, to enforce normative notions of masculinity and femininity, and to recast a social problem as individual pathology. Drawing on published clinical and research papers, archival materials, and interviews with clinicians, researchers, and advocates, this article analyzes early studies of gender-variant boys from the 1960s and 1970s and describes the process through which the GIDC diagnosis was created. The article examines some of the limitations of current debates over GIDC and points out new trends that hold the most promise for providing support to gender-variant children.

Key words: history of psychiatry; scientific controversy; transsexuality; homosexuality; psychiatric diagnosis

This article examines early research on and treatment of gender-variant boys[1] and the ensuing creation of the psychiatric diagnosis Gender Identity Disorder of Childhood (GIDC). It does so in order to make recommendations relevant to contemporary debates over the GIDC diagnosis and to current policy and practice related to the treatment of gender-variant children. GIDC first appeared as a formal diagnosis in 1980 as part of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders—III* (American Psychiatric Association [APA], 1980). Still a psychiatric diagnosis today,[2] GIDC is defined as "a strong and persistent cross-gender identification" combined with "evidence of persistent discomfort about one's assigned sex or the sense of inappropriateness in the gender role of that sex" (APA, 2000, p. 576). Not surprisingly, GIDC and the work associated with it are controversial, with calls from both mental health professionals and lay critics for its reform or elimination (e.g., Bartlett, Vasey, & Bukowski, 2000; Burke, 1996; Butler, 2004; Califia, 1997; Corbett, 1998; Feder, 1997, 1999; Haldeman, 2000; Isay, 1997; Langer & Martin, 2004; Moore, 2002; Morgan, 2001; Pickstone-Taylor, 2003; Richardson, 1996, 1999; Sedgwick, 1993; Wilchins, 1997; Wilson, Griffin, & Wren, 2002).

1 Psychiatric and psychological studies and treatment of gender-variant children have focused primarily on boys. For a discussion of the focus on boys in the early period that I primarily discuss in this article, see Early Work on Gender Variant Boys below.

2 Gender Identity Disorder of Childhood and Transsexualism first appeared in *DSM-III* (APA, 1980) and remained separate diagnoses in *DSM-III-R* (1987). However, in *DSM-IV* (APA, 1994) they were categorized under one overarching diagnosis, Gender Identity Disorder, which included specifications for child, adolescent, and adult variants. For all intents and purposes, the childhood variant of GID is the current version of GIDC and the adult variant of GID is the current version of Transsexualism. The collapsing of these categories and the renaming of Transsexualism as GID has had political fallout, arguably complicating efforts to remove the diagnosis from *DSM*. Throughout the article, I use GIDC to refer to the childhood GID diagnosis. While I could have opted to use GIDC up through 1994, then childhood thereafter, I chose to use GIDC throughout to index the direct lineage of the current diagnosis to the earlier *DSM-III* and *DSM-III-R* diagnosis.

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Critics of the diagnosis and of mental health treatments of gender-variant children argue that GIDC functions to enforce normative notions of masculinity and femininity, to pathologize homosexuality, and to recast a social problem as individual pathology. In the most basic terms, many argue that the diagnosis harms the very children it purports to help.

Within the contemporary critiques of GIDC, there are two broad categories of particular interest for this analysis. Each of these two domains reflects important key concerns of current critiques. First, some critics (e.g., Bartlett et al., 2000; Bem, 1993; Burke, 1996; Haldeman, 2000; Isay, 1997; Moore, 2002; Morgan, 2001; Neisen, 1992; Sedgwick, 1993) have suggested that GIDC functions to pathologize homosexuality by capturing pre-homosexual children in its diagnostic net. Research and treatments of gender-variant boys in the 1960s provided the initial foundation for the creation of GIDC. The hypothesis that these boys would grow up to be homosexual, transvestite, or transsexual adults was a primary legitimating rationale for these studies and treatments. Preventing these possible outcomes was one goal of this early work. Although initially a number of possible outcomes were of interest, the researchers' eventual findings suggested that gender-variant boys would most likely become homosexual men (e.g., Green, 1987; Money & Russo, 1979). The crux of these criticisms stems from the fact that between the time the studies of gender-variant children were begun in the 1950s and 1960s and the time the findings linking them to adult homosexuality were widely reported in the late 1970s and 1980s, the APA removed homosexuality from its list of mental disorders. Critics (e.g., Bem, 1993; Isay; Moore; Morgan; Sedgwick) used GIDC researchers' findings in combination with the APA's delisting of homosexuality to argue that, by practice if not by intent, GIDC continued to pathologize and treat homosexuality.

Critiques of GIDC also fall broadly into a second area that concerns the content of the diagnosis itself (e.g., Bartlett et al., 2000; Burke, 1996; Haldeman, 2000; Langer & Martin, 2004; Richardson, 1999; Wilson et al., 2002). Questioning whether GIDC meets the criteria for mental illness, these critics have examined aspects of the diagnosis—especially the list of diagnostic criteria—for shortcomings and biases. They have argued that GIDC does not meet general criteria for mental illness and have analyzed the specific diagnostic criteria to argue that the diagnosis focuses on behaviors (e.g., cross-dressing) when it should focus on identity (e.g., cross-sex identity statements); that the diagnostic criteria make identity and behavior commensurate; and that the diagnostic net is cast too widely, with, for example, behaviorally deviant children (but not necessarily cross-gender-identified children) included in the diagnosis.

These arguments, developed since the 1980 formalization of the GIDC diagnosis, have revealed shortcomings of both the diagnosis and the mental health treatments associated with it. However, these critiques have also inadvertently bolstered dominant framings of the so-called problems with gender-variant children—framings initially developed by gender researchers in the 1960s (Green, 1967a, 1968, 1971; Green & Money, 1960, 1961, 1964, 1966; Greenson, 1966; Stoller, 1966, 1967, 1968; Zuger, 1966, 1969). In this article, I turn to the period from 1960 to 1980, during which a small group of gender researchers consolidated a medicopsychological subfield on childhood gender variance and created the GIDC diagnosis. Whereas the process by which GIDC became a psychiatric diagnosis has been seen alternately as the result of scientific progress and expert consensus (Zucker & Spitzer, 2005) or as a conspiracy to keep homosexuality under the purview of psychiatry (Bem, 1993; Burke, 1996; McCarthy, 2003; Moore, 2002; Morgan, 2001; Sedgwick, 1993; Wilson et al., 2002), this review shows instead that it was "the result of negotiations, organizational processes, and conflict" (Bowker & Star, 1999, p. 44) and thus "reveals the multitude of local political and social struggles and compromises that go into the constitution of a 'universal' categorization" (p. 47).

A review of this period also exposes some of the limitations of the current critiques of GIDC and associated practices. It illustrates the process through which scientific knowledge about gender-variant children was initially constructed and points to the key constitutive role of debates (Epstein, 1996), both among professionals and between professionals and lay critics, in shaping that knowledge. It shows how critiques have been central in shaping both the diagnosis and the evaluation and treatment practices associated with it, but that these critiques have often been incorporated in ways that jettison their most important critical components. Further, by focusing on adult sexual outcomes (homosexuality), a frame initially developed by the gender researchers themselves, critics have largely missed an opportunity to rethink mental health support for gender-variant children in terms of general psychological health instead of narrow psychosexual outcomes. I conclude by outlining the strengths and weaknesses of current GIDC reform efforts and some of the more promising new directions in mental health practice directed at supporting gender-variant children.

In order to track and evaluate the period from 1960 to 1980, I analyzed a broad range of data from multiple sources. The bulk of this article outlines and analyzes the

period from 1960 to 1980, but I also made use of more recent data in order to mine the historical evidence in terms of its relevance for current debates. In my analysis, I utilized the clinical and research literature on gender-variant children (and later on GIDC) from 1960 to the present; researchers' unpublished papers and correspondence, institutional documents (such as *DSM* committee reports), and community publications (such as fliers, newsletters, and zines) housed in several archives;[3] and interviews with GIDC researchers and advocates who have worked to revise or remove the diagnosis. I also drew on my experiences as an observer and participant at professional and advocacy meetings (e.g., the Harry Benjamin International Gender Dysphoria Association meetings, APA meetings, the National Gay and Lesbian Taskforce Creating Change conferences, and the GenderPAC National Conference on Gender) where discussions of GIDC have taken place.

Early Work on Gender-Variant Boys

Increased medicopsychological interest in gender-variant boys during the post–World War II period set in motion the later inclusion of GIDC in *DSM-III* (APA) in 1980. Beginning in the 1960s, researchers and clinicians began producing a small body of psychiatric and psychological literature on feminine boys (Green, 1967a; Green & Money, 1960, 1961, 1964, 1966; Greenson, 1966; Stoller, 1966, 1967, 1968; Zuger, 1966, 1969). These amounted to the first systematic, aggregate-level studies of gender-variant children.

Gender-variant boys were, of course, nothing new. Why, then, did mental health professionals take them up in a new way at this time—as subjects meriting systematic and sustained research and treatment? Whereas gender variance had been of medical and psychological interest since the nineteenth century or earlier, a series of enabling conditions and events came together in the mid–twentieth century to refigure the meanings attached to gender variance in general and to gender-variant boys in particular. Among these factors were White masculinity crises (Feldstein, 2000; Kimmel, 1996), the ascendance of psychological understandings of personal troubles and public issues (Herman, 1995; Lunbeck, 1994), the gender upheavals of the Depression and World War II, the rising visibility of homosexual communities, and the appearance of transsexuality as a new social subjectivity and medicopsychological problem (Meyerowitz, 2002). Gender-variant boys thus became a target for medicopsychological interest and intervention.

In fact, studies of gender-variant children during this period overwhelmingly examined gender-variant boys (Green, 1967a; Green & Money, 1960, 1961, 1964, 1966; Green, Newman, & Stoller, 1972; Greenson, 1966; Stoller, 1966, 1967; Zuger, 1966, 1969).[4] For the most part, early researchers said little or nothing about their exclusive focus on boys. In fact, they often slid easily from their data on gender-variant boys to discussions of gender-variant children. In an extended exception to this tendency, Green (1968) discussed both the lower rate of what he termed adult female transsexuals (now more typically referred to as female-to-male transsexuals, or FtMs) and the lower (nearly nonexistent) rate of masculine female-bodied children referred to him. For adults, he explained this as a function of broader tolerance for adult female masculinity than for adult male femininity and also, in the case of adult transsexuals, as a result of lower levels of sophisticated surgical interventions available at the time to FtMs, especially concerning the construction of a phallus. For children, he asserted that tomboys were valued in ways that sissies were not, noting that tomboyism was generally understood as a normal developmental phase. In other words, Green tacitly acknowledged the kinds of cultural values and beliefs that undergirded at least the impetus for seeking out treatment for some gender-variant children (boys) and rarely others (girls). While Green acknowledged that tomboys were better tolerated than sissies, they did not escape completely from his diagnostic gaze. Green went on to warn that whereas many girls do in fact grow out of their tomboy phase (for Green [1968], this meant that previous tomboy behavior "does not exclude dating and romance" [p. 503] in adolescence), other tomboys may grow up to be lesbians or transsexuals and must therefore be detected and treated.

Research, treatment, and formal diagnostic criteria for gender-variant children, then, have historically focused more on boys than on girls. Critics (e.g., Feder, 1999; Sedgwick, 1993) have noted that the disproportionate focus on boys was driven by cultural anxieties and reflected a general valuation of masculinity (even to a limited degree in girls) and devaluation of femininity (especially in boys).[5]

3 I collected archival materials at the GLBT Historical Society of Northern California, the Kinsey Institute, University of California, Los Angeles's (UCLA) Special Collections, and the Melvin Sabshin Archives of the APA.

4 For the most significant exceptions to the trend of exclusively studying boys during this period, see Stoller, 1968, chapter 17, and Stoller, 1975, chapter 18.

5 For an alternative interpretation of tolerance vis-à-vis tomboys, see Halberstam (1999). Partially drawing on medicopsychological literatures such as those being analyzed here, she argued that the putative acceptance of tomboys is in large part a myth.

Additionally, specific conditions within the mental health professions made gender-variant boys more obvious and enticing objects of study. Most important among these was the new and controversial professional problem of what to do about transsexual adults, understood at the time as almost exclusively male-to-female transsexuals.

In the wake of the early 1950s media uproar surrounding male-to-female transsexual Christine Jorgensen, ideas about transsexuality and sex change became part of the cultural landscape in ever increasing sectors of society. More people, mostly genetic males but also a few genetic females, began contacting medical experts to request the sex change procedures they had heard about. Surgical and other body-altering procedures were available, but in very small numbers and performed by very few practitioners. Many more professionals advocated curing the mind instead of the body. During the 1960s, most medical professionals in the United States, especially psychoanalysts and psychologists, opposed sex change procedures and argued instead that a psychotherapeutic cure was the appropriate course of action (Meyerowitz, 2002; for studies from this period examining medical and mental health professionals' attitudes toward treating transsexuals, see Green, 1967b; Green, Stoller, & McAndrew, 1968). Others, such as endocrinologist Harry Benjamin (1954), argued that transsexualism had an as yet undetermined somatic basis; therefore, changing the body to suit the mind was the proper intervention and the most humane way of alleviating patient pain. Thus, transsexuality created a great deal of controversy among medical and mental health professionals (see Meyerowitz 2002, especially chapter 3). What to do about it was hotly contested. While solving this professional problem animated deep intraprofessional divides, it also directed researchers toward a new population—feminine boys. Studying and treating this group promised to potentially solve the problem of adult transsexuality through preventing its development in the first place.

To understand and explain the phenomenon of boyhood femininity, researchers drew on new ideas about gender identity developed in 1950s research on intersex infants (Money, Hampson, & Hampson, 1955a, 1955b, 1956, 1957). They also found resources in the form of emerging institutional infrastructure (i.e., university-affiliated gender identity clinics) and government funding for research on the topic. Thus, with a problem before them and the theoretical tools and institutional resources to address it, researchers turned to a patient population that promised the solution, gender-variant boys.

Throughout the 1960s, a few researchers and clinicians working in private practice or in university centers (notably at Johns Hopkins and University of California, Los Angeles [UCLA]) began to publish their reports on small groups or single case studies of feminine boys (Green, 1968; Green & Money, 1960, 1961, 1964, 1966; Greenson, 1966; Stoller, 1966, 1967, 1968; Zuger, 1966, 1969). From then and continuing through to the present, the research and clinical work on gender-variant children has been a small and somewhat obscure subspecialty. In the 1950s and 1960s, there were just a few gender researchers—all men—who worked and published in the area. Key published researchers at the time included Bernard Zuger, a clinician in New York, and Robert Stoller, a psychoanalyst at UCLA. However, most important among the small group were Johns Hopkins' medical psychologist John Money and his student Richard Green. Green and Money began studying gender-variant boys in the 1950s while Green was a medical student, originally as a yearlong student research project with Money as Green's faculty mentor (R. Green, interview with author, September 12, 2003). Their first publication on gender-variant boys appeared in 1960; they eventually published a series of articles across the 1960s that produced some of the first aggregate-level systematic studies of gender-variant boys (Green & Money, 1960, 1961, 1964, 1966). By the end of the 1960s, Green (then an assistant professor in the UCLA Department of Psychiatry and director of its Gender Identity Research and Treatment Program) had emerged as the leading expert in the field of childhood gender variance. Green and Money's publications are still frequently referenced by those in the field as having laid the groundwork for subsequent research and treatment (Zucker, 2000; Zucker & Bradley, 1995).

During this early period, published reports explicitly laid out the legitimating rationale for studying and treating this population and, in the process, both established professional dominance over feminine boys and transformed sissies (or some subset of profound sissies) into a medicalized patient and research population. The researchers argued that whereas most popular and some medical understandings passed off childhood gender variance as just a phase, in fact gender-variant children were at increased risk of growing up to be homosexuals, transvestites, or transsexuals. Therefore, they argued, it was necessary both to study these children to try to understand psychosexual development and to treat them to try to prevent ostensibly suboptimal adult outcomes.

There were variations in the particular outcome—homosexuality, transvestitism, or transsexuality—that each researcher emphasized. Some individual researchers shifted focus over time and between contexts, for example, first emphasizing the putative link between boyhood

femininity and adult homosexuality and later emphasizing its supposed link to adult transsexuality.[6] During the 1960s and early 1970s, however, these shifts were rarely based on concrete data. Rather, the lack of data refuting any of these outcomes, combined with the assumption that boyhood femininity was linked to these outcomes, directed researchers to hold open the possibility that boyhood femininity would result in homosexuality, transvestism, or transsexuality later in life. To remedy the general lack of supporting data on outcomes, researchers called for and began to undertake prospective, longitudinal studies that followed feminine boys (and in the case of one study, matched control "normal" boys) into adulthood. Researchers (e.g., Green & Money, 1964; Zuger, 1969) began reporting follow-ups on gender-variant boys as early as the 1960s. However, the most influential follow-up data were not reported on until the end of the 1970s and the 1980s, with Green's (1987) publication of *The "Sissy Boy Syndrome" and the Development of Homosexuality* providing the most important of these findings.

By the end of the 1960s, the gender researchers outlined the following feminine boys' defining features: They preferred to play with girls, in fantasy play they pretended to be girls and women, they avoided "rough and tumble" play, they cross-dressed frequently, they exhibited "feminine mannerisms," and they sometimes said that they were or wanted to be girls and women. As one set of researchers (Green et al., 1972) succinctly summed things up, "These boys prefer the dress, toys, activities, and companionship of girls, and state their wish to be girls" (p. 213).

While the researchers debated causes without coming to much of a conclusion (their explanations ranged from inchoate biological theories to a range of pathological family dynamics, including the classic overbearing mother/passive father), the tentative nature of their knowledge about both the causes and the outcomes of boyhood gender variance did not translate into hesitation about treatment. While researcher-clinicians reported on a range of treatment approaches (for an overview of several case reports focusing on treatment, see Green et al., 1972; for a detailed case study using classical analysis to treat boyhood femininity, see Greenson, 1966), the overarching goal was the same: to eradicate or reduce the boys' femininity and promote forms of masculinity.

By the beginning of the 1970s, then, a small body of research on gender-variant boys had been established. With the help of federal and private grants, the founding of university-affiliated gender identity research centers, and the publication of a small but growing body of scientific literature on gender-variant boys, a subfield on childhood gender variance began to flourish. Over the course of a few years, a small group of gender researchers had described the features of boyhood femininity, debated its possible causes, developed diagnostic techniques, treated feminine boys and their families, and begun to track long-term outcomes.

New Directions in Research and Treatment

By the late 1960s and early 1970s, UCLA's departments of psychiatry and psychology had become hot spots for the study of gender-variant boys. Green was deep in the throes of what would come to be known as the UCLA Feminine Boy Study, his large-scale, government-funded, 15-year prospective study that compared 66 feminine boys and their families with matched control masculine boys and their families (Green, 1974, 1987). In answering the call for long-term, prospective research, Green's central goal was to shed light on the adult psychosexual outcomes that boyhood femininity actually portended. While some findings from the study did begin to appear in the 1970s (e.g., Green 1974, 1976, 1979; Green & Fuller, 1973a, 1973b; Green, Fuller, & Rutley, 1972; Green, Fuller, Rutley, & Hendler, 1972), Green's longitudinal research design, which allowed him to follow feminine boys into young adulthood, meant that the bulk of his findings would not appear until many years later.

At the same time, a group of researchers in the UCLA Department of Psychology were working on their own projects. They explored several areas, for instance, aiming for more precision in describing gender-variant boys and the features associated with the disorder (e.g., Bates, Bentler, & Thompson, 1979; Bates, Skilbeck, Smith, & Bentler, 1974) and developing diagnostic technologies specifically for use with gender-variant boys and their families (e.g., Bates & Bentler, 1973; Bates, Bentler, & Thompson, 1973). They also worked toward more precision in theorizing about gender variance and the disorders associated with it and proposed a new schema wherein gender-variant boys were divided into two broad categories representing two syndromes: boys with a disorder of *gender role* and

6 For instance, Green and Money (1966) emphasized the link between boyhood gender variance and adult homosexuality, whereas a few years later Green (1971) emphasized the link to adult transsexuality. In contrast, Zuger more consistently than others underscored the link between boyhood femininity and later homosexuality; as early as 1969 he asserted that "follow-up studies on boys with early effeminate behavior (cross-gender identity) have indicated that its manifestations persist and that it subsequently terminates in homosexuality in a large percentage of instances" (p. 375).

boys with a disorder of *gender identity* (e.g., Bentler, Rekers, & Rosen, 1979; Rekers, Bentler, Rosen, & Lovaas, 1977; Rosen, Rekers, & Friar, 1977).[7]

However, among the several new directions and extensions that were in evidence in the UCLA Department of Psychology, one aspect stood out at the time and has in some ways, at least in terms of critiques of GIDC, had the greatest lasting impact: reports on behavior modification treatments of gender-variant boys. Psychologist George Rekers, a member of the UCLA psychology department in the early 1970s,[8] was then and continues to be today most associated with this body of literature. With his focus on altering childhood gender variance through behavior modification techniques, Rekers became a lightning rod for critics. Although the fundamentalist Christian motivation for his work was barely apparent in his early opus, Rekers openly expressed it in later publications (e.g., Rekers, 1982a, 1982b).

Previous work with feminine boys had always implicitly or explicitly sought behavioral change. With boyhood gender variance now established as a legitimate medicopsychological problem and with an equally established set of treatment justifications, Rekers made the goal of changing behaviors the centerpiece of his work. This focus also meshed well with his general theoretical orientation: social learning models of both childhood gender identity and behaviors, or gender roles, as Rekers and his colleagues called these behaviors. These models lent themselves to therapeutic intervention in the form of behavior modification.

Rekers and colleagues' treatments used classic reinforcement techniques to extinguish feminine behaviors and replace them with masculine ones (e.g., Rekers, 1975, 1979; Rekers & Lovaas, 1974; Rekers, Lovaas, & Low, 1974; Rekers & Varni, 1977). They used various reward and punishment systems, including a token economy system in which the boy being treated was given blue tokens for positive reinforcement (e.g., for masculine play with his brother) and red tokens for negative reinforcement (e.g., for feminine play with his sister). At the end of the day, rewards or punishments were doled out depending on the number of each color he had amassed.

The treatments targeted a wide range of behaviors: play activities, play partners (in one case, the researchers tried to reduce time spent playing with the boy's sister, and at the end of treatment reported that the subject's play time with his sister was at "zero or near zero level" [Rekers et al., 1974, p. 106]), gestures, and speech (including "feminine inflection" and "feminine content"). The treatment in each case typically extended over many months.

From the child and family's perspectives, these treatment approaches resulted in a host of new adults intervening in their lives. A small army of researchers and research assistants descended upon the boy and his family—in the clinic of course, but also in the home and the school where they observed periodically (sometimes several visits per week) and trained others to take over as therapist in their absence. As a result, key adults in the boy's life took on new roles. Parents and teachers monitored his behavior in a systematized manner and provided rewards or punishments based on how he performed.

An important and ongoing part of the research concerned questions of both stimulus generalization and response generalization. The researchers looked for stimuli that generalized beyond the specific site or situation where they occurred. They also looked for response generalization, that is, for stimuli that affected a greater range of feminine behaviors beyond the specific one being targeted. In lay terms, they searched for the most effective intervention technique, the magic bullet stimulus that would work across a range of situations and sites (e.g., in the home, the school, and the clinic) and that would work to extinguish a broad range of undesirable behaviors (e.g., feminine speech, mannerisms, play behaviors). Clearly, they did not expect to find a single efficacious cure; however, the focus on stimulus and response generalization remained at the heart of their methodology. As a result, they repeatedly established baseline measures, since it was important to determine whether or not there had been a change in behavior that generalized across sites.

For the child being treated, this meant that the rules of the game were constantly in flux. The behavior that he was asked to modify changed every few weeks. Sometimes the targeted behaviors were cumulative, that is, the child was asked to add new behaviors to the existing repertoire being treated. Other times the new target behavior replaced the old one. In addition, periods of observation without treatment to reestablish baseline measures were interspersed with periods of active treatment. Behaviors that resulted in punishments one week might be ignored

7 These two syndromes went by various names in the publications from the period, including *gender role behavior disturbance/gender identity disturbance* (Rekers et al., 1977), *gender behavior disturbance/cross-gender identification* (Rosen et al., 1977), and *sex-role behavior disturbance/sex-role identity disturbance* (Bentler et al., 1979).

8 Rekers received his PhD from UCLA in 1972 and based his early publications on data from his dissertation (e.g., Rekers & Lovaas, 1974). Although the Green (1987) study and Rekers's (1972) work were separate projects, Rekers generated part of his treatment sample from the boys that Green was studying (R. Green, interview with author, September 12, 2003).

the next, while a new target behavior became the source of everyone's attention.

The First Critiques

It was this body of research—Rekers and colleagues' (e.g., Rekers, 1975; Rekers & Lovaas, 1974; Rekers et al., 1974) reports on various aspects of their behavior modification treatments—that provided fodder for the first wave of published critiques of research on gender-variant boys. By the mid-1970s, critiques of Rekers's work began to appear primarily in professional journals (Morin & Schultz, 1978; Nordyke, Baer, Etzel, & LeBlanc, 1977; Winkler, 1977; Wolfe, 1979) and also in at least one popular outlet (Rorvik, 1975). These writers drew on an explicitly feminist (and sometimes gay liberationist) framework to critique Rekers's treatment of gender-variant boys.

Along with the published critiques, local activists responded to the UCLA programs. In his *Rolling Stone* exposé, Rorvik (1975) reported briefly on the Coalition Against the Dehumanization of Children, a Los Angeles–based group that protested the UCLA child gender program. This coalition condemned childhood gender studies for their complicity in fostering "so-called 'normal masculine role behavior' [which] is nothing more than the outdated stereotype of dominant, competitive, violence-prone males, who are oppressors of women, gays and all peoples" (p. 53).

Critics leveled a number of objections to the work on gender-variant boys, some of which have become permanent features of the ongoing critiques of this body of research. They charged that Rekers's work in particular—and by extension the broader field of research and treatment of gender-variant boys—mistakenly recast a broad social problem in terms of individual pathology. As Rorvik (1975) put it, "How will society ever change if accommodating psychotechnologists keep changing *us* to conform to society?" (p. 53). Nordyke and colleagues (1977) further argued that Rekers and Lovaas evidently accepted and supported existing sex role stereotyping, thereby "failing to contribute to the solution of a larger social problem" (p. 553).

Several critics also questioned the forms of traditional masculinity and femininity that underwrote Rekers's treatment program. Not surprisingly, they also took issue with the specific methods of intervention that Rekers and his colleagues used. For example, Nordyke and colleagues (1977) questioned the severity of Rekers's techniques, citing a basic therapeutic rule to use the least severe intervention possible.

Finally, they all questioned and challenged the legitimating rationale that Rekers and colleagues (Rekers & Lovaas, 1974; Rekers et al., 1974) used to justify their work on gender-variant boys. Rekers and colleagues' rationale had been built on existing justifications established in the 1960s. In the simplest terms, these authors argued that gender-variant children should be treated in order to avoid what they labeled as undesirable adult outcomes, such as transsexuality, transvestitism, and effeminate homosexuality, and because of the disapproval, especially peer disapproval, and social isolation that feminine boys suffered. They asserted that treating gender variance by stamping it out would result in better psychosocial and psychosexual adjustment in the present and the future.

Critics targeting Rekers's work drew on scientific discourses of androgyny from feminist psychology (e.g., Bem, 1974) to support their arguments. This new body of research suggested that androgyny was potentially the healthiest sex role for both men and women. Critics making use of this discourse argued that, instead of working to expand concepts of gendered behaviors and thus moving toward more androgynous outcomes, Rekers's treatment redirected children toward a very narrow set of traditional behaviors and identifications while trying to eradicate cross-gender identifications and behaviors. For instance, Winkler (1977) argued that Rekers's approach, which assumed that stereotypically masculine behaviors would lead to the greatest happiness for boys, might not in fact lead to optimal outcomes. Instead, Winkler turned to Bem's (1974) work and suggested that developing "androgynous target behaviors" (p. 551) might be the best course to take.

Rekers and his colleagues' (Rekers, 1977; Rekers, Bentler, Rosen, & Lovaas, 1977; Rekers, Rosen, Lovaas, & Bentler, 1978) response to this criticism was multifaceted. On one front, they returned anew to their existing justificatory rationale for treating gender-variant children. But they also responded to the critiques in ways that reframed and reinterpreted their own work. These responses encompassed a new way of framing the problem that they purported gender-variant children manifested and new goals concerning the purpose of treatment. Their primary response was to claim that their treatments had always aimed at producing androgynous boys with a wide repertoire of gendered behaviors. In order to show that this was the case, they described gender-variant boys in new ways. Prior to the critiques of their work, descriptions of pretreatment boys focused on the amount of gender-variant behavior the boy manifested. After the critiques began to appear, however, they shifted the focus of their descriptions to the quality of gender variant behavior being manifested. Whereas in the past expressions of femininity had been identified as the primary problem for these boys, now they focused more on the inflexibility and narrowness of

their gendered behaviors, which happened also to be feminine.[9] For example, in their initial report on a patient known as Kraig, Rekers and Lovaas (1974) opened their article by telling us that the population of interest (which Kraig represented) was "young boys with feminine sex-typed behaviors" (p. 173). In a post-critique retelling of the same case study, Rekers (1977) opened his article by describing Kraig as "a 5-yr-old boy with pronounced sex-role inflexibility and stereotypic extremes in gender behavior" (p. 559). In Rekers's new framing, the emphasis had shifted away from Kraig's femininity per se, which in strict terms is not mentioned at all in this description, and focused instead on the rigidness of his gender behaviors.

The gender researchers used other techniques to underscore the move away from femininity as the core problem. They began to illustrate their work with examples of disordered gender other than the feminine boy. For instance, a group of UCLA psychologists (Rekers et al., 1977) opened a post-critique article in the following way:

> Normal children, as they grow, will typically explore the various aspects of their sex-role behaviors. . . . This exploration and flexibility of sex-typed behaviors, typical of many boys and girls, is normal and healthy. On rare occasions, this normal trying out of opposite sex-role behaviors becomes excessive. *One such example is given by the pathological, "super-masculinity" of boys who are violent and can show no gentleness or sensitivity to others. Such boys desperately need psychological treatment* [italics added]. The other extreme is seen in boys who insist that they are girls, rejecting their male role. (p. 2)

In essence, through their strategic use of examples, these researchers suggested that gender disorders occurred across the full gender spectrum and could express themselves in either gender-conforming or gender-nonconforming ways. In one sense, the focus on the inflexibility of behaviors combined with the assertion that these disorders could be expressed across the gender spectrum ostensibly created a level playing field (the disordered gender could be expressed in many ways) where gender per se was not really at the core of the problem.

With the problem effectively redefined, the goals of treatment and solutions sought were also revamped. For example, in a report from the pre-critique period, the researchers' stated goals were "to suppress feminine sex-typed behaviors and to increase masculine sex-typed behaviors" (Rekers et al., 1974, p. 99). Likewise, in their first report on Kraig, Rekers and Lovaas (1974) had described the goal of their work succinctly as "exploring environmental manipulations that might normalize [gender variant boys'] deviant sex-role behavior" (p. 175). However, in Rekers's post-critique version of Kraig's treatment, the goal became "to treat sex-role rigidity" (Rekers, 1977, p. 559).

Rekers and colleagues responded to critiques by drawing on the androgyny literature in seemingly contradictory ways. On the one hand, they claimed that their treatments encouraged an increased range of gendered behaviors, thus echoing core tenets of new androgyny theories. For instance, they said that they aimed for "sex-role flexibility" (Rekers, 1977, p. 561) and the development of select masculine and feminine characteristics (Rekers et al., 1977) in the boys they treated. On the other hand, Rekers argued that the androgyny literature supported treating boys specifically for femininity. Arguing that Bem's findings indicated "high femininity in *females* is not an optimal characteristic" (Rekers, 1977, p. 559), Rekers extended that argument to assert that "high femininity in *males* would be at least equally problematic" (Rekers, 1977, p. 559). While he adopted the androgyny literature in a way that ostensibly created an equal playing field for gender disorders of all sorts, Rekers also drew on that literature to pinpoint both femininity and gender nonconformity as the most disordered gender behaviors, thus leading him back to the feminine boy.

Rekers and others from the UCLA psychology department thus responded to critiques by reasserting old justifications and reinterpreting their work through the lens of feminist psychological research on androgyny. However, their other publications from the same era and later suggested that day-to-day practices in the clinic changed little if at all (e.g., Rekers, 1979; Rekers & Mead, 1979, 1980; Rekers & Varni, 1977; Rekers, Willis, Yates, Rosen, & Low, 1977). Although Rekers and colleagues (Rekers, 1977; Rekers et al., 1977, Rekers et al., 1978) talked about expanding the repertoire of children's gender behaviors, their work continued to focus on eradicating feminine behaviors in boys and replacing them with masculine ones. And while they proposed a broader range of gender disorders, including highly masculine boys and highly feminine girls, their work continued to focus on feminine boys, thus limiting gender disorders in practice to cross-gender behavior and identity in boys. The only real expansion of their research took the form of increasing numbers of masculine girls among their subjects (Bentler et al., 1979; Rekers & Mead, 1979, 1980).

9 In publications from the early 1970s, gender-variant boys' behavior was sometimes typified as inflexible or obsessive. However, these characteristics were not described as the centerpiece of the problem until after the critiques of Rekers and colleagues' work were published in the mid- and late 1970s.

Rekers's newfound emphasis on narrow and obsessive pretreatment cross-gender behavior and posttreatment expansion of behaviors became a mainstay of the subsequent GIDC literature up to and including the present.[10] In essence, debates over the legitimacy of the work on gender-variant children shaped subsequent GIDC discourse and practice. The critiques and their responses changed the ways that researchers and clinicians were encouraged to see and describe gender-variant children. It pushed them to frame the nature of the disorder in ways that were not solely tied to gender nonconformity. They thus developed new justificatory schemes that purported to respond to but in fact sidestepped feminists' objections.

A New Diagnosis, a Continuing Controversy

The 1970s also saw the construction of *DSM-III* (APA, 1980), which provided the framework for the creation of the diagnosis GIDC. The addition of GIDC to the *DSM* would fundamentally shape subsequent research on gender-variant children, as well as the critical response to that work. The diagnosis generated controversy before it was even officially on the books.

The publication of *DSM-III* (APA) in 1980 was nothing less than revolutionary. *DSM-III* responded to a diverse set of pressures facing psychiatry. These included public controversies, waning resources, diminishing professional dominance for psychiatry, and intraprofessional schisms. Psychiatry increasingly faced both internal and external challenges. In short, psychiatry found its legitimacy called into question on a number of fronts.[11]

DSM-III (APA, 1980) responded to this crisis with attempts to employ a more scientific approach to questions of diagnosis. It moved more strongly toward a medical model premised on separate and discernible disease categories and built upon more or less precise, directly observable (often behaviorally based) diagnostic criteria. In addition, *DSM-III* strived for internal consensus by attempting to avoid some points that would be contentious, especially questions of etiology that different schools of thought had approached very differently. Instead, it claimed to be atheoretical and addressed questions of etiology only when there was broad consensus among psychiatrists about the sources of a given disorder. *DSM-III* further aimed for consensus through inclusiveness, with the goal of incorporating all the generally agreed-upon disorders that mental health professionals treated.

Several aspects of *DSM-III* (APA, 1980) cohered well with the existing work on gender-variant boys. For instance, the *DSM-III* framers' desire to avoid discussions of etiology fit well with the lack of findings and agreement concerning the sources of boyhood femininity. More importantly, the behavioral and descriptive bent of *DSM-III* matched perfectly with the emphasis in the existing literature on describing the behavioral components associated with boyhood femininity. Finally, the *DSM-III* goal of exhaustiveness and inclusiveness meant that a diagnosis for gender-variant children—which would affect a small population of patients and would likely be used in a small number of specialty clinics—could still make the cut. The fact that Robert Spitzer—the architect of *DSM-III*—was familiar with Green's work and thus called upon him to write the first draft of the diagnosis helped as well (R. Green, interview with author, September 12, 2003).

The work of making or revising diagnoses for the *DSM-III* (APA, 1980) happened officially via a set of advisory committees, with the entire process supervised by the Task Force on Nomenclature and Statistics. The members of the *DSM* advisory committees were chosen in principle to represent a range of expertise within the committee's broad areas of focus.

In or around 1975, Spitzer asked Green to prepare a document on Gender Role Disorders that would be used in constructing *DSM-III* (APA, 1980) (R. Green, letter to R. Spitzer, December 14, 1976; R. Green, interview with author, September 12, 2003). It was almost certainly in this document that Green wrote the first version of what would eventually become GIDC. Thus GIDC was developed under the auspices of the Gender Identity Disorders Committee of the APA (also sometimes called the Gender Role Disorders Committee and the Gender Identity/Role Disorders Committee), itself a subcommittee of the Psychosexual Disorders Committee (also called the Sex Committee and the Sexual Disorders Committee).

Although others worked on the diagnosis over the next few years, GIDC was in large part the product of Green's work. During this period, Spitzer repeatedly linked the childhood diagnosis[12] to Green, referring to it in one memo

10 In more recent studies, the emphasis on narrow and obsessive pretreatment cross-gender behavior is most apparent in the work of Coates (e.g., 1985, 1990), who developed a trauma theory of the causes of GIDC.

11 For a comprehensive discussion of the shift that *DSM-III* (APA, 1980) represented, and the "legitimation crisis" that it responded to, see Horwitz, 2002; Kirk and Kutchins, 1992; Mayes and Horwitz, 2005; and Wilson, 1993.

12 The diagnosis that would become GIDC went through several name changes while being developed—from Psychosexual Identity Disorder to Gender Role Disorder of Childhood to Gender Identity or Role Disorder of Childhood, and finally to Gender Identity Disorder of Childhood. In this section, unless I am referring to a specific named version of the diagnosis, I refer to it as the *childhood diagnosis*.

as "the category originally described by Richard Green" (R. Spitzer, memo, January 26, 1977). The available evidence (e.g., R. Spitzer, memo, January 26, 1977; R. Spitzer & R. Friedman, letter to R. Green & R. Stoller, December 3, 1976; R. Spitzer & R. Friedman, memo, December 27, 1976; R. Spitzer & R. Friedman, memo, January 5, 1977) suggested that early on (i.e., during the latter part of 1975, through 1976, and into early 1977) there were few major concerns about the childhood diagnosis. The major issues at hand were what to call it (Green had originally termed it Psychosexual Identity Disorder) and whether and how intersex children thought to exhibit gender problems might be included in the diagnosis.

While committee members may have deferred to Green's expertise on matters concerning the childhood diagnosis, the most drastic changes to the diagnosis would not be initiated by Green—they occurred in response to outside critiques. These changes included having separate criteria for diagnosing boys and girls and moving to a clearer focus on issues of identity.

During the spring of 1977, critiques of the diagnosis began to appear behind the scenes. As part of the process for putting together *DSM-III* (APA, 1980), Robert Spitzer circulated draft versions of diagnoses to various constituencies within the mental health professions for their appraisal and input. Either through this process or by other means, San Francisco psychiatrist Ann Chappell, a member of the APA Committee on Women, received a draft of the Psychosexual Disorders diagnoses sometime in the first half of 1977. Chappell was most concerned about three diagnoses—Gender Identity or Role Disorder of Childhood, Other Gender Identity or Role Disorders of Adult Life, and Sexual Sadism. Based on her concerns, she circulated a Dear Colleague letter to members of the Committee on Women and to others in her professional networks. The letter outlined Chappell's objections and asked for recipients to respond with their input. The response to Chappell's call was evidently quite significant. Via both Chappell and through direct correspondence, Spitzer and the advisory committee received what Spitzer characterized at the time as "voluminous correspondence" on the matter (R. Spitzer, memo, July 11, 1977). These letters came primarily from feminist mental health professionals.

The critiques of the childhood diagnosis first and foremost questioned the inclusion of girls in the diagnostic criteria, especially given the fact that the existing research and clinical evidence was based solely on studies and treatment of boys. As one writer put it, "in a civilization in which adult males, by and large, have more status, privilege and power than adult females, it is natural that perceptive little girls would identify somewhat with males" (C. Wolman, letter to R. Spitzer, May 30, 1977). While the bulk of the criticisms focused on how the diagnosis was inappropriate for girls, some extended the criticism of "stereotypes" as applied to boys as well.

Many were also concerned with the ways that the diagnosis mixed together gender role and gender identity. As Chappell put it in her summary letter to Spitzer, "The category tries, but fails, to differentiate true identity confusion from failure to follow sex stereotyped roles in an era of increasing emphasis on androgyny and freeing up from sex role stereotyped restrictions" (A. Chappell, letter to R. Spitzer, June 29, 1977).

Chappell asked letter recipients to make specific recommendations for rewording the diagnosis. Some suggested that the diagnosis be scrapped altogether; others thought it should apply only to boys, or at the very least that it should be split by sex with separate discussions and different criteria for boys and girls. Some suggested that girls have more stringent criteria than boys. Several urged care that "normal" or "moderate" tomboys not be caught up in the diagnostic net. Others had suggestions about how to limit the category to a clear disorder of identity instead of role. For example, Carol Nadelson suggested eliminating all of the "sex stereotyped material" (letter to A. Chappell, June 13, 1977), including references to clothing and play preferences for both boys and girls.

While Chappell's letter writers had clear and trenchant critiques of the diagnosis, most also held on to some notion of (or at least the possibility of) a legitimate childhood gender disorder diagnosis. The clearest illustration of this belief was evident in the way that they had mapped a health/pathology distinction onto a role/identity distinction. For example, one letter writer who argued against treating girls who showed evidence of "masculine role identification" or those who might "develop a homosexual arousal pattern" still maintained that "it is important to treat the very rare pre-transsexual girl" (C. Wolman, letter to R. Spitzer, May 30, 1977). Even those who thought the diagnosis should be scrapped altogether did not dismiss completely the idea of a gender disorder. Instead, they suspended final judgment, noting, for example that "little is really known about these issues and so perhaps waiting to include them until more studies have been reported might be more scientific" (E. Welsch, letter to V. Bernard, May 25, 1977).

In late June 1977 Chappell wrote to Spitzer to summarize the letter writers' concerns about the GIDC diagnosis in formation. Spitzer took the criticisms seriously and along with putting them forward to the committee also invited Chappell to advise the committee on steps it could

take to make the diagnosis more acceptable (A. Chappell, letter to R. Spitzer, October 26, 1977; R. Spitzer, memo, July 11, 1977).

In the next few months the diagnosis underwent significant changes, and in the end the critiques from the Committee on Women had considerable impact on the final diagnosis that appeared in *DSM-III* (APA, 1980). They were successful in moving the diagnosis toward a focus on questions of gender identity, especially as evidenced in anatomic dysphoria. In addition, the diagnosis formed in the wake of their critiques instituted for the first time separate criteria for boys and girls with gender disorder, with narrower diagnostic criteria for girls. In addition, the diagnosis included some small references to the differential social value placed on boys and girls and men and women, and it attempted to acknowledge the ways that this might manifest nonpathologically in girls' gendered behaviors and identifications.

Lessons for Contemporary Debates

In 1980 *DSM-III* (APA) was published and included the diagnosis Gender Identity Disorder of Childhood. After more than 20 years of research and treatment and several years of critique and debates, the work on feminine boys and increasingly on masculine girls had been formalized in the APA's listing of mental disorders. Since then, as outlined at the beginning of this article, the diagnosis has been subject to critique with the debates over its legitimacy escalating over the course of the 1990s. Current critiques have sometimes drawn on earlier published works, for instance using Rekers's work as an example of either the most egregious form of treatment gender-variant children have been subjected to (e.g., Bem, 1993) or as the paradigmatic example of the typical treatments gender-variant children have received (e.g., Burke, 1996; Feder, 1997). However, the early work that I have reviewed, including the first critiques of the childhood gender disorder concept, have been overlooked in their potential to fully inform current debates. So, what can be learned from the early period that I have been outlining?

In a very basic sense reviewing this history draws attention to the way that clinician-researchers constructed the notion of feminine boys in response to their own professional needs and interests. This early work on boyhood femininity established several important and enduring orienting frames. Specifically, researchers defined gender variance as a problem, thus directing their attention toward signs of pathology instead of, for example, resiliency. They also defined the clinical phenomenon and its indicators largely in terms of sets of behaviors instead of, for example, meanings, identity, or even existence or extent of psychic pain. And their work was largely fueled by their interest in a narrow set of possible adult outcomes, namely sexual orientation and gender identity instead of, for example, general psychosocial adjustment.

While scientists of various stripes tend to understand their work as a form of discovery of what already exists, my review of the early studies of gender-variant boys shows the ways that researchers also framed and constructed the concept of feminine boys in response to their own existing professional concerns and crises. In so doing, they responded to taken-for-granted assumptions about the nature and value of gender and sexual nonconformity. Many critics over the years have challenged aspects of these framings. However, there are portions of the original orienting frames that live on, even in and through the critiques that would otherwise challenge GIDC and the work associated with it. For example, the assumption that gender variance is necessarily, in some form or another, evidence of pathology has permeated both the defenses and the critiques of GIDC. While this has not universally been the case—Corbett (1997), for example, warned against mapping a health-pathology model onto a gender conformity-nonconformity continuum—some critics have argued that certain forms of nonpathological gender nonconformity be excluded from the diagnostic net by identifying (or at least hinting at) the truly pathological forms of gender variance (e.g., Bartlett et al., 2000; Haldeman, 2000; Richardson, 1999).

This approach overlaps with another way in which the early framings have endured, even via critiques. As I have shown, the will to understand (and control) psychosexual development has motivated the research on gender-variant children. As such, there has been a deep interest in the adult sexual orientations and gender identities of gender-nonconforming children. For clinicians who treat GIDC, this has been (and continues to be) partly motivated by the promise of preventing some outcomes and encouraging others. For many contemporary critics, there has also been a clear interest in psychosexual outcomes, although with an important twist. Drawing on the findings from longitudinal studies of gender-variant children, critics have noted that large portions of GIDC children will grow up to be homosexual (e.g., Bartlett et al., 2000; Bem, 1993; Burke, 1996; Haldeman, 2000; Isay, 1997; Moore, 2002; Morgan, 2001; Neisen, 1992; Sedgwick, 1993). Some of these critics have then mounted a critique of GIDC in the name of protecting pre-homosexual children, citing the APA delisting of homosexuality and arguing that because they will eventually grow up to be homosexual—a nonpathological

outcome—pre-homosexual children should not be pathologized and treated during childhood using GIDC.[13] This may seem like a legitimate, logical, and strategically savvy use of researchers' findings to challenge their own clinical work. However, it reinforces the original framing device of understanding the behaviors of gender-variant children as precursors of adult sexual orientations and gender identities only. The goal therefore becomes protecting certain kinds of children (specifically, pre-homosexual children) from the GIDC diagnosis based on their presumed adult sexual orientation. With this approach, however, we risk losing a focus on the possible negative effects of GIDC diagnoses and treatments on the general psychosocial (not psychosexual) adjustment of all GIDC children, regardless of their eventual adult sexual orientation and gender identity.[14]

Just as the history of early framings has important lessons for the contemporary moment, so do the first round of critiques that took place in the mid- and late 1970s. With some small amount of historical distance on this period, the outcomes of the early debates—such as the critiques of Rekers's treatments and the reformulations of the diagnosis-in-formation within the APA—are easier to see. Scientific controversies, either between lay and scientific groups or schisms among scientists, have become the site for important analyses of the production of scientific knowledge. Scholars have shown, for example, the ways that lay interests can mobilize to either promote (e.g., Arksey, 1994; Riessman, 1983; Rittenhouse, 1991; Scott, 1990) or challenge (e.g., Bayer, 1987; Figert, 1995) existing or potential medical categories. Others have examined schisms among scientists and have argued that even dissenting views among scientists, including positions that are never adopted, are key in the construction of scientific knowledge (Armstrong, 1998). Epstein (1996) brought these strands together in his examination of the interplay of AIDS activists and a variety of claims about AIDS based on scientific knowledge. He argued that "knowledge emerges out of *credibility struggles*" (p. 3). In other words, scientific controversies, both controversies among scientists and controversies fueled by lay interests, are key sites for the construction of subsequent scientific knowledge.

The early debates that I have outlined underscore Epstein's (1996) contention that knowledge emerges from credibility struggles. But with respect to GIDC it is important to consider the eventual form that resulting knowledge has taken; what have these credibility struggles wrought? In the case of critiques of Rekers's work that drew on feminist theories of androgyny, I have outlined a process of cooptation whereby the critiques were absorbed into the researchers' own work in a way that ignored the spirit and deep substance of those critiques. Critics drew on new feminist psychology to call for a thorough rethinking of the way that gender-variant children were defined as a problem and to question the behavioral treatment approaches used to treat gender-variant boys. Although Rekers and his colleagues responded by also adopting the language of feminist psychology, their work continued to define gender-variant children as a problem and their treatment approaches continued to encourage gender conformity as a solution to that problem.

The effects of this round of critiques can also be detected in later omissions from official knowledge about gender-variant children. Whereas the 1960s and 1970s publications included many detailed accounts of the treatment of gender-variant boys, usually in the form of the single case study report, the treatment literature began to dwindle in the 1980s. Making an assessment of the contemporary state of GIDC treatment literature, a leading GIDC defender told me that "there are no systematic, comparative, treatment studies . . . nobody ever publishes data about what happens in therapy" (interview with author, October 22, 2003). While there are several explanations for the paucity of treatment literature, including the way that the appearance of an official diagnosis shifted knowledge production to questions of diagnostic reliability and validity, it is plausible that the critiques of Rekers's treatments played a part in encouraging GIDC researchers and clinicians to focus their published works on areas other than issues related to treatment.

13 Critics' focus on homosexuality is also a function of the way that the APA's delisting of homosexuality is interpreted as analogous to contemporary efforts to remove GIDC from the *DSM*. While both GIDC critics and defenders note many parallels between the ultimately successful efforts to delist homosexuality and current critiques of GIDC, they are distinct in important ways. For instance, the effort to delist homosexuality had the full force of a burgeoning social movement behind it (see Bayer, 1987); efforts at reforming or delisting GIDC have been piecemeal at best and primarily (although not exclusively) take place as intraprofessional debates.

14 Zucker and Spitzer (2005) challenged some critics' (Bem, 1993; McCarthy, 2003; Moore, 2002; Morgan, 2001; Sedgwick, 1993; Wilson et al., 2002) interpretation that GIDC was a backdoor mechanism for keeping homosexuality under the purview of psychiatric control. Instead they argued that GIDC's (and transsexualism's) entrée into the *DSM* was primarily the result of "expert consensus" (p. 31). Although they made several important points concerning the limitations of conspiracy theory interpretations of the inclusion of GIDC in the *DSM*, they do not fully address the historical forces leading to GIDC's inclusion discussed in this article. In addition, they do not address the varied ways in which GIDC may function to reinforce homophobic forces; for a more complete discussion, see Bryant (2006a).

An area where there was seemingly more successful leveraging of critique is found in the APA Committee on Women's interventions with the diagnosis-in-formation. To understand the full impact of these critiques, however, it is necessary to look forward to the way the diagnosis has evolved since its initial formation. Throughout the revision process, the diagnosis has gradually gone through a process of domain expansion, whereby increasing numbers of children can potentially be caught up in its diagnostic net. One of the ways that this has occurred has been through making the girls' and boys' diagnoses more equivalent.[15] Thus, in some ways the original gains resulting from the letter-writing campaign have been rolled back. However, another important issue to examine is the effectiveness of these gains in the first place. While the diagnosis did give guidelines about whom to diagnose, these were in no way hard-and-fast (the literature is replete with discussions of subclinical populations of children who are studied and sometimes treated). Further, an important omission from the *DSM* is a discussion of the kinds of treatment that GIDC children should receive. (This omission is a general orientation of the *DSM* and not unique to GIDC). Beginning with the APA Committee on Women and continuing up to the present, critics have devoted a great deal of energy to critiquing and reworking the diagnosis itself, but the actual impact that the diagnosis has may be quite limited and can have both positive and negative effects. The *DSM* certainly has important symbolic and material effects; however, these effects are varied and limited. While the GIDC diagnosis makes a value statement about forms of childhood gender variance (i.e., that they can be pathological and should be treated), the actual day-to-day uses of the diagnosis are less clear. The *DSM* is full of residual categories (the Not Otherwise Specified diagnoses) and general diagnoses that can be used as substitutes in cases where a clinician decides that he or she does not want to give a diagnosis such as GIDC.[16] Removing or revising the diagnosis may have little to no impact on the actual practices of clinicians who work with gender-variant children. In fact, if the diagnosis were to be removed from *DSM*, it is plausible that the kinds of debates reviewed in this article—debates that have shined light on existing mental health approaches to gender-variant children—might dwindle, thus allowing existing clinical approaches to operate off the critical radar. In addition, the diagnosis may have unforeseen positive effects. One of the earliest and most prominent critics of GIDC told me in an interview that he has come to see the diagnosis as a red herring in advocacy work for gender-variant children. Among other things, he pointed out that the diagnosis has actually proven beneficial in some instances, for example in securing rights for children in public schools to dress in the manner that is appropriate for their gender identity (interview with author, May 21, 2003).

Conclusions: Looking Back and Moving Forward

How, then, given the existence of GIDC, can we support and advocate for gender-variant children within the context of mental health service provision? The picture I have painted seems bleak. Challenges to dominant knowledge formations are met with incorporation or disregard and potential gains turn into losses or turn out to be inconsequential. I believe that the putative failures of the critiques are due in part to their narrow focus on GIDC itself. When the focus of critiques is narrowly on the GIDC diagnosis, they can be commandeered and reframed by GIDC supporters.[17] There needs to be, therefore, a reorientation in focus away from GIDC in particular and onto the general psychosocial health of children, specifically here on gender-variant children. In this case, revising or eliminating the diagnosis becomes secondary to the more immediate (and I would argue more important) task of developing new models of mental health support for gender-variant children.

I want to end by suggesting that the development of the new models that I am calling for has in fact begun. And, while the critiques I examined have had limited utility in changing the immediate target of their criticism (that is, the GIDC diagnosis itself), they have actually been instrumental in catalyzing the beginnings of a cultural shift in the mental health professions vis-à-vis the meanings attached to childhood gender variance. It is this cultural shift that holds the most promise for generating new models of affirmative support for gender-variant children.

15 For example, whereas in *DSM-III-R* (APA, 1987) girls but not boys had to state a desire to be the opposite sex in order to qualify for the diagnosis, in *DSM-IV* (APA, 1994) neither girls nor boys needed to make such statements.

16 One published GIDC researcher and clinician reported that she never used the GIDC diagnosis in her work with gender-variant boys (interview with author, December 2, 2003).

17 For both for its critics and defenders, a narrow focus on GIDC is made infinitely more problematic in light of recent developments attributable largely to transgender activism. The proliferation of new meanings of gender variance and the associated appearance of new social subjectivities arguably render GIDC untenable in ways not fully explored here. For a discussion of these and related issues, see Bryant (2006b).

Many critics have fought for specific reforms, from tweaking GIDC's diagnostic criteria to eliminating the diagnosis altogether. Yet, arguably their greatest impact has been to draw attention to the shortcomings of status quo mental health approaches to gender-variant children and, in doing so, to open up intellectual terrain where practitioners and others can imagine new ways of providing services to gender-variant children. Alternative approaches (e.g., Menvielle & Tuerk, 2002; Children's National Medical Center, 2003) that do not define the gender-variant child as the problem have begun to appear and are beginning to infiltrate terrain that was once held solely by GIDC researchers and clinicians. Their reorientation to gender-variant children has, for example, redefined the problem not in terms of the gender variance itself but instead in terms of the stigma to which gender-variant children are subjected. As such, the goal of mental health service provision becomes helping children and their families cope with stigma instead of trying to change gender-variant behavior itself (e.g., Menvielle & Tuerk). It is these kinds of programs that hold out the greatest promise for a future where mental health professions play a key role in providing meaningful support to gender-variant children.

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FOR IMMEDIATE RELEASE
May 26, 2010

The *World Professional Association for Transgender Health* has prepared and released a statement urging the de-psychopathologisation of gender variance worldwide. The statement is as follows:

The WPATH Board of Directors strongly urges the de-psychopathologisation of gender variance worldwide. The expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally-diverse human phenomenon which should not be judged as inherently pathological or negative. The psychopathologlisation of gender characteristics and identities reinforces or can prompt stigma, making prejudice and discrimination more likely, rendering transgender and transsexual people more vulnerable to social and legal marginalisation and exclusion, and increasing risks to mental and physical well-being. WPATH urges governmental and medical professional organizations to review their policies and practices to eliminate stigma toward gender-variant people."

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